Policy Procedures Summary of Changes

Policy	Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)
1	BH	BH-001	Behavioral Health Services	The policy establishes guidelines and procedures to ensure the well-being, safety, and effective treatment of AAH members.	Updates to AAH GroupCare MH/SUD inpatient admissions	X		
2	BH	BH-005	Care Coordiantion for Behavioral Health	The Alliance's Behavioral Health (BH) Department is responsible for this care coordination. Members who are identified as possibly benefiting from, or who request case management including complex case management and enhanced case management will be referred to the Alliance's medical case management program.	BH Care Coordinators Role in Care Coordination	X		
3	BH	BH-006	Care Coordiantion for Substance Abuse	BH-005 is all enocompassing for care coordination within the BH Dept and BH-006 can be retired.	RETIRE POLICY			
4	CBAS	CBAS-001	Initial Member Assessment and Member Reassessment for CBAS Eligibility	Describes process UM follows to create initial and ongoing CBAS Auths	Removed verbiage about a non-regulatory letter that was previously sent to the member/ Center. This process was stopped by UM effective 9/25/24 and this policy update aligns that process. Also added language to identfiy a MCP designee for the process	X		X
5	CMDM	CM-009	Enhanced Care Management Program Infrastructure	ECM Program infrastructure in alignment with DHCS policy guide for ECM	annual review			X
6	CMDM	CM-010	Enhanced Care Management - Member Identification and Grouping	Member identification and risk grouping for ECM program	annual review			X
7	CMDM	CM-011	Enhanced Care Management - Care Management & Transitions of Care	ECM members are thoroughly assessed. Health Action Plans are developed to assist in the management of the member's needs.	annual review			X
8	CMDM	CM-013	Enhanced Care Management - Oversight, Monitoring & Controls	Auditing and oversight of ECM providers	annual review			X
9	CMDM	CM-014	Enhanced Care Management - Operations Non-Duplication	Non-duplication of services	annual review			X
10	CMDM	CM-016	Enhanced Care Management - Staffing	Required staffing structure for ECM	annual review			X
11	CMDM	CM-018	Enhanced Care Management - Member Notification	Member identification and member notification of ECM services	annual review			X
12	CMDM	CM-XXX	Child Welfare Liaison	Clarify the intent and objectives of the Medi-Cal MCP Child Welfare Liaison role	creation of P&P in alignment with DHCS' APRL 24-013		X	

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13	CMDM	UM-016	Transportation Guidelines	Structure of Plan's Transportation Benefit	Updated APL Citations APL 23-006 DELEGATION AND SUBCONTRACTOR NETWORK CERTIFICATION replaces APL 17-004 Subcontractual Relationships and Delegation APL 22-013 PROVIDER CREDENTIALING / RE-CREDENTIALING AND SCREENING / ENROLLMENT replaces APL 19-004 Provider Crednetialing / Recredentialing and Screening / Enrollment	X		
14	CMDM	UM-016	Transportation Guidelines	Structure of Plan's Transportation Benefit	Addition of language regarding transportation liaison and PCS form for 2023 DHCS FA.	X		
15	QI	QI136	Clinical Practice Guidelines	Describes how the Alliance adopts, disseminates, and monitors the use of preventive care and other clinical practice guidelines in alignment with DHCS contract requirements	Updated to include guidelines as specified in DHCS APL 24-008 Immunization Requirements	x		
16	Quality	QI-107	Appointment Access and Availability Standards	Describes how the Alliance implements and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care from all applicable provider types.	Updated policy to comply with the NCQA accreditation standard of 10 Business Days for Psychiatrist	x		
17	Quality	QI-114	Monitoring of Access and Availability Standards	Describes how the Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegae network.	1. APL 23-015-Timely acces to care standard are noted in the Provider Data and Directories DAT-001 2. Updated policy to include TAR, MCAHPS, HOS survey 3. Updated policy to include BH and Specialist as part of CG-CAHPS survey	x		
18	Quality	QI-116	Provider Appointment Availability Survey (PAAS)	Describes the PAAS survey process designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members.	1)APL 24-017-Add definition of a pattern of non-compliance rate (fewer than 80%) for NPMH provider follow-up appointment, and Timely Access standard for follow-up non-urgent appointment with NPMH provider 2) Upated policy to align with DMHC PAAS methodology to additionally include Dermatology, Neurology, Oncology, Opthalmology, Otorlaryngology, Pulmonary, and Urology.	x		
19	UM	UM-011	Coordination of Care- Hospice and Terminal Illness	Describes the process for authorization and care coordination for members receiving Hospice Services	Annual Review- updated spelling, grammar, formatting and QIHEC References			X
20	UM	UM-018	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and treatment	Describes the EPSDT services and the relationship between the plan and Regional Center to ensure members care is coordinated effeciently.	Annual Review- updated spelling, grammar, formatting and QIHEC References			X
21	UM	UM-023	Communicable Disease Reporting and Services	Describes the process for the plan to hold the community providers responsible for reporting communicable diseases to the Local Health Department and our requirement to authorize services related to those communicable diseases	Annual Review- updated spelling, grammar, formatting and QIHEC References			X

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22	UM	UM-030	Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)	Describes the role and responsibility for closed loop referral into WIC	Annual Review- removed verbiage about updated referral form and then included the verbiage in guidance about annual notification of member eligibility.	X		X
23	UM	UM-033	Topical Fluoride Varnish	Benefit coverage fluoride varnish, safety to apply, and medical practice steps to provide oral preventive screening/ assessments, and FV applications.	FV intervention guidance and procedure is described in DHCS language, added FV safety addressed for multiple applications, updated language for dental referrals after medical screening; added quality data measures for this intervention; added related policies; added references	X		X
24	UM	UM-035	Care Coordination- Vision Services	PSDT	Annual Review- updated committee title and formating.			
25	UM	UM-047	UM Sub-Committee	Discusses the UM Committee's roles and responsibilites	Annual review, updates HCQC to QIHEC. Added titles for UM director, LTSS Director, LTSS Medical Director. Added content review of LTSS and CalAIM UM functions	X		X
26	UM	UM-051	Timeliness Standards	Discribed the timelines	Annual Review/ Removed duplicated section- attached the new excel grid that references all UM timelines that follow the strictest guidances from DHCS, DMHC and NCQA which aligns with processes taken by the Alliance UM teams.	X		X
27	UM	UM-055	Palliative Care	Criteria and scope ofPalliative services for pediatric and adult members	Annual review; updated populations impacted by the Transition Guide and PHM Guide, alignment with the WIC, updated citations to Pediatric Palliative waiver/ Patient Protection and Affordable Care Act; updated qualifying Palliative care condition for advanced dementia/ Alzheimer's dementia that was added in 2023 referral form but not added to Policy; updated Palliative member and provider notification pathways; Referrals sources including CBAS, TCS and Special Populations for the 2024 MCP Transition Guide. Delegation oversight added. Definitions expanded; updated References.	X		X
28	UM	UM-057	Authorization Service Request	Reviews all UM functions and criteria used to create authorizations	Included verbiage related to the authorization and/or denial of non-benefit and unlisted codes. Updated spelling, grammar, formatting and QIHEC references	X		
29	UM	UM-068	Tertiary and Quaternary Review Process	Criteria and review of academic level of care for complex and rare conditions, or diagnostic or therapies that are not available in the community setting for specialty care.	Added Alta Bates Summit Comprehensive Cancer Center, Adult Cellular Therapy Program for Bone Marrow Transplants only. All active Centers of Excellence are listed for cancer care.	X		X
30	UM	UM-071	Major Organ Transplant	Policy to discuss the process for Authorizing Major Organ Transplant	Annual review- updated the organ list impacted by the program. Updated the verbiage related to the Urgent Auths			
31	UM	)51 Attachm	Timeliness Standards Attachment Grid	Grid showing the updated timelines	Sunset this policy/ attachment- will include the new grid in as an attachment built within the UM 051 Policy	X		X

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32	UM	UM-053	Breastfeeding Lactation Management Aids and Supports	Benefit coverage for breast feeding bumps and supplies, nutrition services and donor human breast milk.	Updated guidance from AAP and ACOG; updated DHCS indications for breast bump DME; added Pasteurized Donor human breast milk coverage and criteria, and nutritional counseling services related to breastfeeding. Added definitions, added impacted depts, & references	X		X
33	UM	UM-054	Notice of Action	Describes regulatory requirements for NOA enclosures	Annual Review- Formating updated	X		X
34	UM	UM-063	Gender Affirming Surgery & Services	Outlines criteria for GA authorized services	Annual Review - Updated hair removal language, updated gender affirming language, removed hormone criteria for adult ≥18 yo surgeries.	X		X
35	UM/ BH	UM-003	Concurrent Review and Discharge Planning Process	UM and BH use to complete the Concurrent reviews	BH added verbiage r/t to their process. Removed on site review lanuage, updated the discharge risk assessment verbiage to match the newest guidance provided in the PHM FAQ June 2024 document related to the d/c risk assessment	X		X
36	Utilization Management	UM-070	UM Denial System Controls	Describes UM system controls policies and procedures to monitor and protect data from being altered outside of prescribed protocols	annual review; added monitoring requirements if audit findings are not resolved after consecutive quarters	X		X
37	Grievances & Appeals	G&A-001	Grievance and Appeals System Description	Outlines the grievance system used by the Plan	No change, annual review			X
38	Grievances & Appeals	G&A-002	Grievance Filing	Outlines the process of how members, member representatives and providers on behalf of the member can filing a grievance.	No change, annual review			X
39	Grievances & Appeals	G&A-003	Grievance Receipt, Review and Resolution	Outlines the process when receiving, revieiwing and resolving grievances and appeals	No change, annual review			X
40	Grievances & Appeals	G&A-004	Member Education / Notification Requirements	Outlines the process on our member notification requirements, with inlcude education on how to file a grievance.	No change, annual review			X
41	Grievances & Appeals	G&A-005	Expedited Review of Urgent Grievances	Outlines our process for processing expedited grievances.	No change, annual review			X
42	Grievances & Appeals	G&A- 006	Independent Medical Review	Outlines the member's process when requesting an independent medical review when their healthcare services have been denied, modified or delayed by the Plan or a contracted provider	No change, annual review			X
43	Grievances & Appeals	G&A- 007	State Fair Hearing	Outlines the process for members to request a State Fair Hearing when issuing a Notice of Appeal Resolution (NAR) inidicating the request was upheld	No change, annual review			X
44	Grievances & Appeals	G&A- 008	Adverse Benefit Determination Appeals Process	Outlines the process for resolving appeals of adverse benefit determiantions.	Language regarding timely filing and written consent was updated to handle the appeal as a grievance if requirements to handle as an appeal are not met.	X		
45	Grievances & Appeals	G&A- 009	Provider Grievances	Outlines the formal process to accept, acknowledge, and resolve provider grievances	Retiring due to provider grievance language being removed from our current DHCS contract	X		
46	Grievances & Appeals	G&A- 010	Medi-Cal Rx	Outlines the process for addressing member grievances and appeals related to pharmacy for Medi-Cal members	No change, annual review			X

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47	Grievances & Appeals	G&A- 011	UM Appeals System Controls	Outlines the UM appeals system process and control to protect data from being altered outside of prscribed protocols	No change, annual review			X

POLICY AND PROCEDURE

Policy Number	BH-001
Policy Name	Behavioral Health Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	MCAL, IHSS
Effective Date	03/21/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	4/19/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

A. Alameda Alliance shall provide the following Behavioral Health Services when they are provided or ordered by a licensed health care professional acting within the scope of his or her license:

1. Individual/group Mental Health evaluation and treatment (psychotherapy);
2. Psychological testing when clinically indicated to evaluate a Mental Health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation for medication management;
5. Outpatient laboratory, supplies and supplements;
6. Alcohol Misuse Screening and Counseling (AMSC) for Members who misuse alcohol, in accordance with Alameda Alliance Policy BH-006 Coordination of Care-Substance Abuse
7. Family therapy (composed of two (2) or more family members) for adult Members with a Mental Health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
   a. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.

B. Alameda Alliance collaborates with Alameda County Behavioral Health (ACBH) and contracted mental health providers to gather and share member's mental health treatment information for the purposes of care coordination. PHI is shared securely to ensure

member information is protected and viewed only by authorized staff and treating providers for the purpose of care coordination.

C. Alameda Alliance refers members to the ACBH ODS program for SUD treatment. Alameda Alliance ensures that member privacy and data security for SUD treatment is maintained according to State and Federal guidelines including 42-CFR. Member authorization to release information allowing treatment history, active treatment, and health information to be exchanged in obtained as required by law.

D. For Members under the age of twenty-one (21), Alameda Alliance shall provide Medically Necessary non-specialty Menal Health services listed in Section II A of this Policy, regardless of the severity of the impairment.

E. For Members under twenty-one (21), Alameda Alliance shall provide medically necessary behavioral health treatment services. See policy P&P BH-004 Behavioral Health Therapies (BHT)- Applied Behavioral Analysis (ABA).

F. Alameda Alliance shall *not* impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by Alameda Alliance, in accordance with the parity in Mental Health and substance use disorder requirements in Title 42 Code of Federal Regulations (CFR), §§ 439.900-438.930.

G. For Group Care Members Alameda Alliance manages all levels of care (including but not limited to outpatient, intensive outpatient, residential and Inpatient) for mental health and SUD conditions. For Group Care Members Alameda Alliance does not require prior authorization for emergency MH/SUD inpatient admissions but does require prior authorization for residential services, intensive outpatient services, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation.

1. Alameda Alliance will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.
2. Alameda Alliance will require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system only if the plan's prior authorization requirements comply with California Code, HSC § 1374.721.
3. If there is a disagreement between Alameda Alliance and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to with California Code, HS C§ 1374.721 at a level of care consistent with utilization review criteria pursuant to Section with California Code, HSC § 1374.721
4. Alameda Alliance will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with California Code, HSC § 1374.721.
5. If contacted by a 988 center, mobile crisis team, or other provider of behavioral health

Commented [VE1]: Recommendation. Can we refer to P&P BH-004 Behavioral Health Treatment (BHT)- Applied Health Analysis (ABA)? And remove steps 1-9. This will prevent us from updating two policies for changes specific to BHT. Please advise.

Commented [CP2R1]: Yes

Commented [VE3]: What is the regulation e.g. CCR, CFR. U.S.C, etc.?

Commented [CP4R3]: Don't know. This was taken word for word from the DMHC language.

Commented [VE5R3]: I was able to locate the regulation California Code, HSC § 1374.721

crisis services, Alameda Alliance will either authorize post stabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for post stabilization care.

6. To the extent permissible under federal law, the plan will not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one post stabilization telephone call to the number provided in advance by the plan.
7. Alameda Alliance will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the post stabilization telephone call to the plan to be a physician or surgeon.

H. Alameda Alliance shall use tools mutually agreed upon with Alameda County Behavioral Health (ACBH), administered by Alameda Health System (AHS) to assess the Member's disorder, level of impairment, and needed care.

I. Through a network of licensed Mental Health care Providers, Alameda Alliance shall provide Behavioral Health Services to Members with Mild to Moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group Mental Health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a Mental Health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.

J. Alameda Alliance and its contracted Primary Care Providers (PCPs) shall provide AMSC for Members identified as at-risk of alcohol misuse in accordance with Alameda Alliance Policy.

K. Alameda Alliance and its contracted PCPs shall be responsible for screening and providing Mental Health services within the scope of their practice.

L. Alameda Alliance shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with Alameda Alliance Policies: Tracking and Reporting Disclosures of Protected Health Information (PHI), Protected Health Information Disclosures Required by Law, Use and Disclosure for Treatment, Payment, and Health Care Operations. (CMP-005 Minimum Necessary Use & Disclosures)

M. Alameda Alliance shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with Alameda Alliance Policies: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, Member Authorization for the Use and Disclosure of Protected Health Information.

N. Alameda Alliance shall maintain and monitor an appropriate provider network and ensure

timely access to Behavioral Health Services as set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and Alameda Alliance Policy: QI-108 Access to Behavioral Health Services.

O. If Behavioral Health Services that are the responsibility of Alameda Alliance are unavailable to the Member within the network, Alameda Alliance shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with Alameda Alliance Policy: UM-057 Authorization Service Request.

P. Alameda Alliance shall not require a referral from a PCP or Prior Authorization for an initial Mental Health assessment performed by a network Mental Health Provider. In addition, Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with Alameda Alliance Policies and APL 22-005 (No Wrong Door for MHS) Prior Authorization requirements shall be in compliance with the requirements for parity in Mental Health and substance use disorder benefits in Title 42 CFR section 438.910(d).

Q. Alameda Alliance shall provide a direct telephone call center for emergencies during non-business hours for Members to access and for Providers to coordinate care or to access the nearest emergency room during a crisis.

1. Alameda Alliance shall ensure:

    a. Timely access to screening of Members for Mild to Moderate Behavioral Health Services using the age appropriate DHCS approved Screening Tool;
    b. Appropriate staffing levels of the call center; and
    c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to Alameda Alliance Policy: Cultural and Linguistic Services.

2. Alameda Alliance shall ensure its call center staff have relevant knowledge to:

    a. Provide information regarding Covered Services;
    b. Identify the location, qualifications, and availability of Providers within the Alameda Alliance Behavioral Health Provider network;
    c. Inform Members of their rights and responsibilities, in accordance with Alameda Alliance Policy: Member Rights and Responsibilities;
    d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with Alameda Alliance Policies, Member Grievance and Appeal Process;
    e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with Alameda Alliance Policies, Alameda Alliance Provider Complaint and Appeal Process;
    f. Access oral interpretation services and written materials in Threshold Languages for Members;
    g. Provide information on other community services or resources available to Members; and

Commented [VE6]: Policy title updated
Commented [CP7R6]: Good
Commented [CP8R6]: Good
Commented [VE9]: Policy title updated
Commented [CP10R9]: Good
Commented [CP11R9]: Good
Commented [VE12]: Update Needed. Is this policy "CLS-008 Member Assessment of Cultural and Linguistic Needs"? Will need to update the title. Section 5. speaks to free language assistance services. Please advise.
Commented [VE13]: Unable to locate "Member Rights and Responsibilities" Policy. Please advise.
Commented [CP14R13]: I think this lives in compliance

h. Educate the Member regarding the procedure and department at Alameda Alliance to contact if the Member would like to change their Health Network or has questions about Health Network options.

R. Alameda Alliance shall identify and refer an eligible Member to ACBH for the provision of Medi-Cal Specialty Mental Health Services.

S. Alameda Alliance shall identify and refer an eligible Member to the County Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

T. Alameda Alliance's Behavioral Health Department performs the care management and utilization management functions requiring behavioral health expertise and experience. The Alliance integrates behavioral health into it's UM, CM and QI program descriptions, work plans and annual evaluations to ensure parity and enable the Alliance's efforts to provide integrated whole person healthcare services.

U. Alameda Alliance's Behavioral Health Department provides Care Management and Utilization Management for Mental Health and Autism Services. The Behavioral Health Department is overseen by the Senior Director of Behavioral Health and the Senior Medical Director. The Senior Medical Director is an Emergency Medicine Physician and the Senior Director of Behavioral Health is a licensed psychologist. Together, they are responsible for Behavioral Health Care Management and Utilization Management processes and level of care determinations. The Behavioral Health Department is staffed by licensed Mental Health clinicians including LCSWs, LMFTs, BCBAs, RNs and Behavioral Health navigators.

PROCEDURE

A. PCP and Behavioral Health Services

1. For alcohol misuse, a PCP shall:
   a. Administer the DHCS-approved screening tool for identifying alcohol misuse in accordance with DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
   b. Provide behavioral counseling intervention on identified issue(s); and
   c. Refer to ACBH for additional assessment and counseling when indicated.

2. For Mental Health, a PCP shall:

   a. Screen and provide Mental Health services within the scope of their practice; and
   b. Refer the Member for further Mental Health services through Alameda Alliance's and / or ACBH's Mental Health Provider Network.

Commented [VE15]: Update needed. APL 18-014 superseded. APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Please advise.

Commented [CP16R15]: Yes use the updated APL

B. Accessing Alameda Alliance Behavioral Health Services

1. A Member may access Behavioral Health Services through the Alameda Alliance Member Services Phone Line.

2. A Member may be referred to the Alameda Alliance Member Services Phone Line from the following:

   a. Alameda County Mental Health Plan (ACBH) ACCESS Line;
   b. Self-referral;
   c. Authorized Representative or caregiver;
   d. PCP;
   e. Specialty Care Provider;
   f. Behavioral Health specialist;
   g. Long-Term Support Services (LTSS) Provider;
   h. Community-based agency;
   i. Case manager, Disease Management staff, or discharge planner; and
   j. Other Providers of a Member's health care team.

C. Alameda Alliance Member Services Phone Line

1. Call Center requirements shall include:

   a. Complying with telephone access standards in accordance with Alameda Alliance Policy: QI-107 Appointment Access and Availability Standards: & MBR-062 MS Referrals and Triage

   b. Utilizing linguistic interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication;
   c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;

      i. If the caller is a Alameda Alliance Medi-Cal Member assigned to Kaiser Foundation Health Plan (Kaiser), Alameda Alliance shall refer and provide the caller the Kaiser phone line to access services.
      ii. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Alameda County Social Services or provide enrollment information and suggest a community resource for treatment of their described symptoms.

   d. Determining if the caller is seeking help for a Mental Health concern;
   e. Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;
   f. If a caller's needs are indicated as requiring Emergent or Urgent Services including when a caller who potentially presents as a danger to self or others, call center staff shall transfer the caller to the Alliance BH Care Management Team and/or County's Crisis Response services without delay to prevent further deterioration of

Commented [VE17]: Clarification and updated needed for policy is this referring to "QI-107 Appointment Access and Availability Standards". Please advise.

Commented [CP18R17]: Please use the updated reference to QI-107

the caller's condition;

g. Call center staff must link Emergent calls to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than two (2) hours after determining the call is emergent;
h. Call center staff must transfer urgent calls for services to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than within twenty-four (24) hours after making the determination that the call is urgent;
i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to the Alliance Behavioral Health Care Management Team (Clinician) and:
j. If the Caller is determined to be a Medi-Cal beneficiary assigned to Alameda Alliance with a Mental Health need, the call center staff shall conduct a brief telephone clinical screening tool approved by DHCS to verify appropriate level of services and transfer/refer members meeting the threshold criteria for Specialty Mental Health Services to the ACBH Access Team to initiate appropriate mental health services.
k. The member services staff will use the DHCS approved screening tool to determine the need for a referral to Alameda County Behavioral Health of moderate to severe services. Member services will transfer/refer members to the ACBH Access Team to initiate appropriate mental health services.

2. As a result of the brief telephone clinical screening using the DHCS approved Screening Tool:

   a. If it is determined the Member meets Mild to Moderate need for Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the Alameda Alliance Behavioral Health Network, are currently accepting Alameda Alliance Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to Alameda Alliance Policy: Access and Availability Standards.
   b. If determined the Member does *not* meet Mild to Moderate need for Behavioral Health Services and rather does meet for Serious Mental Illness (SMI), the call center staff will warm transfer the member to the Alliance BH Care Manager who will complete the DHCS clinical assessment and transition of care form and subsequently transfer the member to ACBH ACCESS where the Member will establish appropriate services consistent with APL 22-005 No Wrong Door for MHS.

      i. Based on screening, member will be referred to ACBH if member has:
         a. An included diagnosis for services with ACBH
         b. A significant impairment in an important area of life functioning or a reasonable probability of deterioration in an important area of life functioning
      ii. Member can also initiate services by self-referring to an Alliance contracted provider. The Alliance contracted provider to complete the initial screening during the first initial assessment appointment. If based on the screening, member meets criteria for Specialty Mental Health Services, current provider

to notify Alliance BH department to refer the member to ACBH for services utilizing the DHCS approved Transition of Care Tool.

iii. Transfer/refer members to ACBH Access Team:
    a. If during clinical review or during the course of treatment the behavioral health provider determines that member meets criteria for Specialty Mental Health Services through the Mental Health Plan, BH Case Manager will coordinate with member and current behavioral health provider to transition member to the ACBH for services. BH Case Manager will ensure successful linkage to ACBH for services consistent with "closed loop" referral requirements.

c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to ACBH for Drug Medi- Cal services.

3. Alameda Alliance shall ensure the following steps are completed during the Member call:

    a. Member's eligibility status and Health Network assignment shall be verified each time the Member contacts the Alameda Alliance Member Services Phone Line;
    b. A safety screening and an age-appropriate Screening Tool approved by DHCS will be completed, the outcome/results of the screening, and if applicable, any resources/Provider referrals that were provided; and
    c. Warm transfer to the Alliance BH Care Management Team for further clinical assessment based on the Safety Screening and protocols for identification of urgent and emergent access to care.

D. Care Coordination

1. Alameda Alliance shall coordinate Mental Health care for Members enrolled in the Enhanced Care Management (ECM)and Community Supports (CS) in accordance with Alameda Alliance polices for ECM and CS.

    a. Alameda Alliance shall ensure compliance with all applicable State and federal requirements related to ECM and all CSS requirements determined by DHCS.
    b. Alameda Alliance shall ensure Members are receiving appropriate and coordinated services.

2. Alameda Alliance shall ensure care coordination with ACBH is addressed in interagency Alameda Alliance/ACBH Collaboration Meetings to ensure:

    a. Provision of all Medically Necessary Covered Services; and
    b. Identification and referral of eligible Members to LTSS based on Member's Plan of Care.
    c. When Alameda Alliance is determined to be responsible for covered Behavioral Health Services, Alameda Alliance shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the ACBH.
    d. Transition of care is provided for Members transitioning to or from Alameda

Alliance or ACBH Mental Health services in compliance with APL 22-005 (No Wrong Door for MHS) requirements. ACBH clinical consultation, including consultation on medications, shall be provided to Alameda Alliance's PCPs who are treating Members with mental illness;

3. Coordination of care for Inpatient Mental Health treatment:

    a. ACBH requires that inpatient hospital Providers notify a Member's PCP within twenty-four
    (24) hours of admission and discharge from an inpatient Mental Health treatment to arrange for appropriate follow-up services.
    b. To facilitate transition of care for Members transiting to or from ACBH Mental Health services, Alameda Alliance's PCPs and the outpatient Behavioral Health Providers treating
    Members with mental illness shall receive clinical consultation, including consultation on medication from ACBH.
    c. Alameda Alliance and contracted Health Network PCPs and the outpatient Behavioral Health Provider shall review and update the care plan of the Member as clinically indicated.

4. Services provided Simultaneously by Alliance and ACBH

    a. ACBH and Alameda Alliance will coordinate provision of prescribing psychiatrists and psychiatric NPs who are serving Alameda Alliance members; and
    b. Ensure non-duplicated specialty Mental Health services provided through ACBH, including psychiatric medication management, can be provided simultaneously with Mental Health services provided by Alameda Alliance network providers when clinically appropriate.

5. Emergency Services

    a. Alameda Alliance shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in Alameda Alliance Policy: Transportation: Emergency, Non- Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission;
    b. Alameda Alliance shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's Mental Health or medical condition; and
    c. As the County Mental Health Plan, ACBH provides emergency assessment of the Member's Mental Health condition through their Crisis Services Team and designated Emergency Departments throughout Alameda County.

6. Information Exchange

    a. Alameda Alliance shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and Behavioral Health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.

7. Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Specialty Mental Health Provider; and

8. Members are receiving services from ACBH and/or Drug Medi-Cal program.

DEFINITIONS

Term	Definition
Appeal	A review by Alameda Alliance of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both Mental Health and substance use disorder services, as covered by Alameda Alliance.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially

	significant improvement in human behavior.
Alameda Alliance Member Services Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call to obtain referrals for all Alameda Alliance Covered Outpatient Mental Health Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

Term	Definition
Child with Serious Emotional Disturbance (SED)	Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the Alameda Alliance program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under Alameda Alliance's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the Alameda Alliance Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For- Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi- Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.

Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Generally accepted standards of mental health and substance use disorder care	Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Term	Definition
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Grievance	An oral or written expression of dissatisfaction, about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Enhanced Care Management Program (ECM)	This program is required by DHCS to replace the prior Health Homes Program and is designed to provide targeted services and resources for members who meet ECM criteria in order to provide additional support and Care Management services for members with complex needs.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable Alameda Alliance policies.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Alameda Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Alameda Alliance program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Alameda Alliance or Business Associates and relates to: 1. The past, present, or future physical or Mental Health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Rehabilitation services, which include Mental Health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric inpatient hospital services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; and 5. Early Periodic Screening, Detection, and Treatment (EPSDT) Specialty Mental Health Services
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity for the condition.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews including:
Behavioral Health,
Case and Disease Management,
Grievance and Appeals,
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-005 Second Opinions
UM-014 CoC-Identifying Abuse
UM-015 Emergency Services and Post Stabilization Services
UM-016 Transportation Guidelines
UM-036 Continuity of Care

Commented [VE19]: Policy title updates

Commented [CP20R19]: I do not have an updated policy in the BH Dept so I am assuming you are inserting UM-014 as the update which is fine.

UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Service Requests
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 Complex Case Management Plan Development and Management
CM-004 Care Coordination of Services
CM-011 Enhanced Care Management – Care Management & Transitions of Care
MBR-062 Referrals and Triage

Commented [VE21]: Policy title updates

Commented [CP22R21]: These are all UM and CM Policies so if they are the most up to date please include the ones highlighted

Commented [VE23]: Policy title updates

Commented [CP24R23]: Same as above

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 3/21/2023
Revisions: 6/12/2024, 08/08/2024

REFERENCES

- Alameda Alliance Contract with Department of Health Care Services (DHCS)
- Memorandum of Understanding with ACBH
- Alameda Alliance Policy: Member Rights and Responsibilities
- Alameda Alliance Policy: Cultural and Linguistic Services
- Alameda Alliance Policy: Appeal Process
- Alameda Alliance Policy: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
- Alameda Alliance Policy: Authorization for Psychological Testing for Mental Health Conditions
- Alameda Alliance Policy: Access and Availability Standards
- Alameda Alliance Policy: Alameda Alliance Provider Complaint
- Alameda Alliance Policy: Member Grievance
- Alameda Alliance Policy: Tracking and Reporting Disclosures of Protected Health Information (PHI)

- Alameda Alliance Policy: Protected Health Information (PHI) Disclosures Required by Law
- Alameda Alliance Policy: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
- Alameda Alliance Policy: Member Authorization for the Use and Disclosure of Protected Health Information
- APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non- Specialty Mental Health Services
- DHCS All Plan Letter (APL) 21-014: Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
- DHCS APL 22-005 No Wrong Door for Mental Health Services Policy
- DHCS APL 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders
- Medi-Cal Provider Manual – Part 2: Psychological Services
- California Code of Reg., Title 9, §§ 1810.370(a)(3), 1830.205 and 1830.210
- Welfare and Institutions Code, § 14132.03
- Welfare and Institutions Code, § 14189
- 42 CFR, §§ 438.900-438.930
- 42 CFR, § 438.910, subd. (d)
- California Code, Health & Saf. Code, § 1374.721.

Commented [VE25]: Is this referencing a general policy guide? Or should they be reflective of department-specific policies? Please advise.

Commented [CP26R25]: This was originally take from UM and CM references we received from Alison's predecesor. Please check to see if these references are still accurate or if they have more specific policy references.

Commented [VE27]: Update needed, APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)

Commented [CP28R27]: Please include this update.

Commented [VE29]: Citation update

Commented [CP30R29]: Thanks for the update.

Commented [VE31]: What is the regulation e.g. CCR, CFR. U.S.C, etc.?

Commented [CP32R31]: Don't know. This was taken word for word from the DMHC language.

MONITORING

The Compliance, Quality Improvement and Behavioral Health Departments will annually review this policy for compliance with regulatory and contractual requirements. All policies will be brought annually to the Quality Improvement Health Equity Committee (QIHEC), and Administrative Oversight Committee for review and approval.

POLICY AND PROCEDURE

Policy Number	BH-005
Policy Name	Behavioral Health – Care Coordination for Behavioral Health
Department Name	Health Care Services
Department Officer	Chief Medi-Cal Officer
Department Owner	Senior Director, Behavioral Health Care Services
Lines of Business	Medi-Cal, Group Care
Effective Date	
Subcommittee Name	Quality Health Equity Committee
Subcommittee Approval Date	
Compliance Committee Approval Date	

POLICY STATEMENT

A. Behavioral Health Care Coordination (CC) services are available to all Alliance members. The Behavioral Health Care Coordination Referral process supports members in accessing mental health (MH), substance use disorder (SUD) and behavioral health treatment/applied behavioral analysis (BHT/ABA) services. The Alliance's Behavioral Health (BH) Department is responsible for this care coordination. Members who are identified as possibly benefiting from, or who request case management including complex case management and enhanced case management will be referred to the Alliance's Medi-Cal case management program. The Alliance retains responsibility for assuring continuity of care and care coordination. The Alliance staff collaborates with both members and providers to coordinate this care.

B. Referrals for Behavioral Health Care Coordination (CC) may be received from network providers, members themselves, internal departments within the Alliance, and Alameda County Behavioral Health (ACBH).. All referrals Behavioral Health CC case managers (CM) will be documented within the Alliance's Clinical Information System. CC referrals may be received from any source and by any medium but most commonly phone, fax, e-mail, or member/provider portal.
Member participation in CC is voluntary. This will be communicated to members, caregivers, and providers when a CC referral is made.

C. The Alliance maintains workflows and processes to ensure no duplication of services occurs. When duplicative services are identified by CM staff members, efforts are made to collaborate and transition the member as needed to limit service duplication. as appropriate. The CC staff will continue to provide care coordination services until the member is fully transitioned to other entities.

D. The Alliance implements information-sharing processes and referral support infrastructure. The Alliance ensures appropriate sharing and exchange of member information and Medi-Cal records with providers in accordance with Alliance Policy, CMP-005, Minimum Necessary Use & Disclosures.

PROCEDURE

A. Referrals for Care Coordination and Case Identification
   1. Members may call member services for information regarding the mental health/substance use disorder benefits, and referrals for MH/SUD providers. Member services behavioral health staff provide initial care coordination services to low complexity members. Member services staff identify members with increased complexity or acuity, and refer to BH for care coordination per MBR-062 Member Services Clinical Referral and Triage Process.
   2. Alliance staff in utilization review, Medi-Cal case management, enhanced case management, long-term care and community support services may also identify and refer potential members for CC.

B. Referral Screening
   1. BH CM staff will:
      a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System daily. Referrals will be entered into the referral summary for review by a clinician. Cases identified as elevated risk will be identified and assigned to clinical staff and processed within 1 business day. If at any time, the Manager of BH CM, clinical staff or referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

         For Medi-Cal members, BH CC staff will conduct a MH screening to determine which system of care they are able to receive services in. This assessment is required by DHCS. Members scoring a 6 and over on the DHCS MH Screening Tool will be referred to ACBH ACCESS for care within the ACBH SMHS system. Members scoring a 5 and under will be referred to providers within the Alliance network. BH CC staff coordinate care with ACBH ACCESS via direct contact with ACCESS staff members via secure email daily, and face to face meetings which are scheduled to occur every two weeks. The goal of these care coordination activities is to ensure that members have accessed care, and

that any additional care needs not addressed by the ACBH will be addressed by the Alliance BH CM staff to ensure members are linked with the appropriate care.

C. BH Care Coordinators Role in Care Coordination

1. BH CM members identified for Care Coordination criteria will be assigned to appropriate BH CM staff (clinician or Health Navigator) based on clinical needs and complexity.

2. The BH CM Staff will assess and coordinate with the appropriate agency to ensure access to care. The Alliance will provide care coordination for members, including locating, arranging, and following up to ensure services were rendered when such treatment is medically necessary for a member.

3. BH CM staff will identify members who may be eligible for services offered through external agencies, including but not limited to the Alameda County Organized Delivery System for SUD services, ACBH Specialty Mental Health, Regional Center of the East Bay (RCEB), California Children's Services, and Alameda County Office of Education/Local Education Authorities.

4. For Medi-Cal members, the BH CM staff will ensure that there is no duplication of services with ACBH specialty mental health services. ACBH will provide case management for members within SMHS or SUD programs with ACBH. The Alliance staff will work collaboratively with ACBH staff to provide case management and care coordination as required.

5. For Group Care members, the Alliance will schedule the appointment or arrange for the admission with the out-of-network providers for the enrollee within the following time limits:

   a. No more than 10 business days after the initial request for non-urgent MH/SUD services:
   b. Within 15 business days of a request for a specialist physician MH/SUD services
   c. Within 48 hours of the initial request for urgent MH/SUD services if no prior authorization is required
   d. Within 96 hours of the initial request for urgent MH/SUD services if prior authorization is required
   e. Within 24 hours of the scheduling of the out-of-network appointment or admission accepted by the enrollee, the plan must provide the enrollee, the enrollee's authorized representative, or the enrollee's provider with information regarding the appointment or admission.

6. For Group Care, if the plan is unable to arrange for covered services as set forth above the enrollee or the enrollee's representative may arrange for care from any appropriately licensed provider, so long as the appointment or admission occurs no more than 90 days after the initial request for services.

7. For all members, BH CM staff will work to identify network providers to meet members' needs. If services are not available to meet members' clinical needs, or within timely access and distance requirements, BH CM staff will collaborate with members to identify an out of network provider.

D. Medi-Cal Expedited Dispute Resolution Process

1. The Alliance may seek to enter into an expedited dispute resolution process if a member has not received a disputed service (s) and the Alliance and/or ACBH determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.
   a. AAH and ACBH will have one business day after identification of an expedited dispute to attempt to resolve the dispute at the plan level.
   b. Within one business day after a failure to resolve the dispute in that time limit, both plans will separately submit a Request for Resolution to the Department of Healthcare Services (DHCS), as set out above, including an affirmation of the stated jeopardy to the member.
   c. If ACBH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the Alliance. Conversely, if the Alliance fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBH.

E. Financial Liability

1. If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services, the Alliance or ACBH is required to comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530.

F. Confidentiality

1. The Alliance maintains Business Associates Agreements (BAA) with its contracted provider network. Provisions in these agreements ensure the Alliance's members Medi-Cal and behavioral health information is kept confidential as information is shared as part of the care coordination process. For Medi-Cal members, the Alliance has a memorandum of understanding that further describes the information sharing with ACBH.
2. The Alliance's Member Services department maintains an information release form for authorization to release mental health records/information.

DEFINITIONS

Alameda County Behavioral Health/ACCESS- Alameda County Behavioral Health has a centralized intake service for Medi-Cal members with mental health and substance use disorder evaluation and treatment services. This service can accessed by calling 1-800-491-9099.

Behavioral Health Provider – the Alliance network of behavioral health care providers.

Behavioral Health Services includes the range of assessment, referral, treatment and follow up services for mental health, substance abuse disorders and behavioral treatment for neurodevelopmental disorders.

California Children's Services (CSS)- The CCS program provides diagnostic and treatment services, Medi-Cal case management, and physical and occupational therapy services to children under age 21 with CCS-eligible Medi-Cal conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic Medi-Cal conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides Medi-Cal therapy services that are delivered at public schools. See Program Overview (ca.gov)

Mental Health Services may be provided on an inpatient and outpatient basis and include treatable mental disorders such as severe mental illness and stress related conditions.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directo–s - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership. See Home - RCEB

AFFECTED DEPARTMENTS/PARTIES

Provider Services Utilization
Management Case
Management Behavioral
Health Member Services

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENT

BH-001 Behavioral Health Services
BH-004 Behavioral Health Therapies (BHT): Applied Behavioral Analysis (ABA)
CM-001 CCM Identification Screening Enrollment and Assessment
CM-004 Care Coordination of Services
CM-029 Developmental Disabilities
CM-30 Early Start
CM-032 Care Coordination- Local Education Agency Services
CMP-005 Minimum Necessary Use & Disclosure
MBR-062 Member Services Clinical Referral and Triage Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Memorandum of Understanding- Alameda County Behavioral Health Services and Alameda County, April 2023.

REVISION HISTORY

11/21/2006, 4/1/2011, 6/1/2011, 9/7/2012, 3/5/2013, 7/12/2013, 12/26/2013, 12/30/2013, 4/7/2014, 4/13/2015. 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023 Changed from UM-012 to BH-005 on 3/19/2024, 10/09/2024

REFERENCES

1. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11.Provision 6. A and B; 12. Provision 3 and Attachment 21
2. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
3. MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
4. MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
5. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health, and Substance Use Disorder Coverage
6. NCQA QI 9 Standard Continuity and Coordination Between Medi-Cal Care and Behavioral HealthCare
7. DHCS All Plan Letter 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide

Services to Members with Eating Disorders
8. DHCS All Plan Letter 22-005 No Wrong Door for Mental Health Services
9. DHCS All Plan Letter 22-006 Medi-Cal Managed Care Health Plan Responsibilities for NSMHS
10. DMHC All Plan Letter 24-07 Implementation of SB 855 Regulation, Mental Health, and Substance Abuse Coverage
11. Medicaid Mental Health Parity Final Rule (CMS-2333-F)
12. Behavioral Health Information Notice (BHIN) 21-073
13. California W&I Code sections 14059.5 and 14184.402
14. United States Code (USC) Section 1396d(r)(5) of Title 42
15. CCR Section 53855 of Title 22

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee, and Compliance Committee annually.

POLICY AND PROCEDURE

Policy Number	BH-006
Policy Name	Coordination of Care – Substance Abuse
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Senior Director, BH Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	03/19/2024

POLICY STATEMENT

A. Alameda Alliance for Health (the Alliance) PCPs are responsible for identifying Members with active or potential substance abuse problems.
B. Once Members are identified, PCPs are responsible for providing services for the substance abuse problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance abuse problem.
C. PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner.
D. Members referred for substance abuse treatment remain enrolled in the Alliance and the assigned PCP remains responsible for all necessary health care.
E. The Alliance does not require prior authorization for referral to Substance Abuse Disorder (SUD) evaluation or treatment.

PROCEDURE

A. Acute medical conditions related to alcohol or substance abuse.

    1. Medically necessary care for acute medical conditions related to alcohol or substance abuse, such as delirium tremens or gastrointestinal hemorrhage, is provided by the PCP or by specialist referral if necessary.

    2. Members are referred for outpatient treatment or transferred to a mental health

practitioner when medically stable.

B. PCPs are responsible for identifying Members with substance abuse problems.

1. PCPs must include assessment of substance abuse during the initial health evaluation performed within 120 days of enrollment (see CLS-008 Member Assessment of Cultural and Linguistic Needs).
2. Subsequent contact with the Member also affords PCPs the opportunity for evaluation of the Member's health and questions regarding substance abuse problems.
3. PCPs provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) per the processes outlined in AAH policy HED-006 SABIRT, and APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.
    a. If a provider is unable to provide SABIRT, the PCP refers the Member to a provider who can provide SABIRT services. The referral and subsequent treatment do not require prior authorization.

C. PCPs should consider substance abuse as a potential issue for Members that present with the following conditions, history, and/or requests:

1. Elevated liver enzymes without evidence of a specific causal factor such as hepatitis, other viral illnesses, medication induced, etc.
2. Repeated skin infections, particularly abscesses or sterile abscesses on the trunk, arms, or legs, with or without needle marks (tracks).
3. Repeated requests for narcotic pain relievers without physical evidence of genesis of pain.
4. History of endocarditis.
5. Prior history of substance abuse.

D. Members with substance abuse problems can also be identified in the following ways:

1. Utilization Management (UM) department staff may refer Members to Case/ Disease Management for assessment and appropriate follow-up actions based on:
    a. Multiple referrals for 'pain control', abnormal liver tests, Hepatitis B or C sequelae, among others.
    b. Discharge planning of individuals hospitalized for substance abuse sequelae (i.e., endocarditis).
2. Identification may also occur through:
    a. Member Services referrals
    b. Grievances
    c. Alliance Pharmacy Staff identify Members using large numbers of narcotics and other potentially addictive medications.
    d. Alliance specialists seeing Members for conditions listed above and suspect substance abuse problems are responsible for informing the PCP and referring the

Member to an appropriate program.

E. The PCP must discuss recommendations for treatment with the Member and:

1. Develop a treatment plan, and/or

2. Refer as appropriate to an acute detoxification program, inpatient treatment program, residential treatment program, or day treatment program through the Behavioral Health department, Alameda County Alcohol and Other Drugs Program or Medi-Cal FFS as appropriate.

F. PCPs are responsible for all necessary health care for Members with substance abuse problems. Depending on the specific substance abuse problem and the health status of the Member, services may include:

1. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);

2. Limited mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; and

3. Referral to specialty practitioners for evaluation as necessary (e.g., cardiology evaluation for valvular defects secondary to endocarditis).

G. The PCP has primary responsibility for referral to the appropriate substance abuse service with assistance from Alliance Behavioral Health/Utilization/Case Management departments. The PCP will:

1. Identify individuals requiring alcohol and or substance abuse treatment services and arrange for their referral to the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers, for appropriate services.

2. Assist Members in locating available treatment service sites.

3. To the extent that treatment slots are not available in the California, Department of Alcohol and other Drugs Program (ADP) within the plan's Service Area, the Alliance will pursue placement outside the area.

4. Continue to ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment. The Alliance will coordinate services between the primary care providers and the treatment programs.

H. With assistance from the Alliance, the PCP is responsible for relaying pertinent medical information to assist with the referral. Copies of medical records are sent to the substance abuse provider whenever necessary to facilitate the transition into a treatment program.

I. Members may also self-refer for substance abuse services to the appropriate AAH Behavioral Health network or Alameda County Alcohol and Other Drugs Program. The Alliance Member Services is available to assist Members as needed at (510) 747-4567.

J. If a member presents at a general acute care facility for voluntary inpatient detoxification (VID) services but does not meet medical criteria for inpatient admission, the Alliance will coordinate with Alameda County Behavioral Health Care Services to refer the member to the necessary substance use disorder (SUD) treatment services. Substance Use Treatment and Referral Helpline is 1-844-682-7215 and is available 24 hours a day/7 day a week.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.
B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    c. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.
C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.
F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent.
G. AAH understands and will comply with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.
H. AAH Behavioral Health RN Care Managers and Triage Specialists have been trained to use the American Society of Addiction Medicine (ASAM) Criteria® (ASAM) when reviewing Substance Abuse cases. All Substance Abuse CM and UM processes are overseen by the

Senior Director of Behavioral Health who is a Licensed Psychologist to ensure ASAM criteria is applied and authorizations for substance abuse services are provided appropriately.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. HED-006 SABIRT
2. BH-002 Behavioral Health Services
3. UM-002 Coordination of Care
4. CMP-019 Delegation Oversight

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 02/07/2018, 04/15/2019, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 6/20/2023, 03/19/2024

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 7
2. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11. Provision 6. A and B; 12. Provision 3 and Attachment 21
3. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
4. MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
5. MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
6. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance

Use Disorder Coverage

7. American Society of Addiction Medicine (ASAM) Criteria®

MONITORING

The Compliance, Behavioral Health and Utilization Management Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee and Compliance Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Alliance follows Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS) as well as for periodic reassessments of eligibility determinations.

Alameda Alliance for Health (AAH) ensures the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Ensures appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS is trained by DHCS on using the approved assessment tool.
B. Conducts the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations include a face-to-face or Telephonic review of the Member. The assessment team includes a Registered Nurse with level of care experience, either as an employee or as a sub- contractor.
C. AAH shall reassess and re-determine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.
D. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, AAH may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

E. AAH shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. AAH's written notice shall be approved by DHCS and include procedures for grievances and appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6, (Member Grievance and Appeal System.)
F. AAH shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

PROCEDURE

The Alliance Out of Plan team receives a CBAS-interest call from the following sources:

- Self, family and/or caregiver
- Primary Care Provider (PCP)
- Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
- CBAS provider/center
- Home or Community-Based Organization (HCBO)
- Acute care hospital (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)
- Skilled nursing facility, acute-care facility (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)

The Alliance CBAS Out of Plan RN contacts the member/authorized representative to confirm interest in CBAS services and ascertain administrative eligibility. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.

If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.

When the Alliance receives a referral for eligibility determination the following processes occur, although the ordering of the processes may vary according to individual cases:

1. Alliance CBAS team receives initial referral of a member to CBAS.

i. Out of Plan RN makes first attempt to schedule Face-to-Face assessment within 5 calendar days of initial referral.
    a. the RN makes two additional attempts via telephone to schedule between five (5) and eight (8) calendar days of initial referral
    b. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.
    c. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

ii. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:
    a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

i. Denial of CBAS program:
    a. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.
    b. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.
    c. Grievance and Appeals
        - A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
        - A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approval of CBAS program:
    a. Eligibility determination is communicated to the member and her/his authorized representative within two (2) business days.
    b. Authorization to conduct Individual Plan of Care (IPC) is communicated to

the member's chosen CBAS provider within one (1) business day of the decision.

At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

5. CBAS center staff:
   i. Performs three (3) day multidisciplinary team assessment.
   ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation
   iii. Submits a Prior Authorization request to the Alliance.

6. The Alliance:
   i. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.
      a. If the Alliance cannot make a decision within five (5) working days of receiving the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.
      b. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, Independent Medical Review, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day.
      c. Grievance and Appeals
         - A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
         - A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.
   ii. Approved services are authorized for a six-month period.
      a. Member is notified within 2 Business Days of authorization.
      b. Center is notified within 1 Business Dayof authorization.

7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.
   i. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in

circumstances occurs that may require a change in the member's CBAS benefit.

ii. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

iii. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

iv. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

   a. The Member's name and ID number
   b. The name(s) of the Member's Physician(s)
   c. If applicable, the date of the Notice of Action denying authorization for CBAS was issued
   d. If applicable, the date the CBAS benefit will be terminated
   e. Specific information about the Member's current medical condition, treatments, and medications
   f. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge
   g. Contact information for the Member's case manager
   h. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

v. Communication and Coordination of Care

   a. AAH will coordinate with the CBAS provider to ensure:
      - Timely exchange of the following coordination of care information:
      - Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
      - Clear communication pathways between the appropriate CBAS Provider and staff and AAH staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.
   b. AAH will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in AAH policies and procedures related to CBAS.

DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long Term Care

RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 4/9/2024, 09/25/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01

MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn- around-time.

POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	~~Manager, OP UM~~Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~5/19/2023~~
Compliance Committee Approval Date	TBD~~6/20/2023~~

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POLICY STATEMENT

The Alliance follows Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS) as well as for periodic reassessments of eligibility determinations.

Alameda Alliance for Health (AAH) ensures the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Ensures appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS is trained by DHCS on using the approved assessment tool.
B. Conducts the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations include a face-to-face or Telephonic review of the Member. The assessment team includes a Registered Nurse with level of care experience, either as an employee or as a sub- contractor.
C. AAH shall reassess and re-determine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.
D. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, AAH may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

~~E. AAH shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care experience and utilizing the assessment tool approved by DHCS.~~

~~F.~~E. AAH shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. AAH's written notice shall be approved by DHCS and include procedures for grievances and appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6, (Member Grievance and Appeal System.)

~~G.~~F. AAH shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

PROCEDURE

The Alliance Out of Plan team receives a CBAS-interest call from the following sources:

- Self, family and/or caregiver
- Primary Care Provider (PCP)
- Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
- CBAS provider/center
- Home or Community-Based Organization (HCBO)
- Acute care hospital (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)
- Skilled nursing facility, acute-care facility (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)

The Alliance CBAS Out of Plan RN contacts the member/authorized representative to confirm interest in CBAS services and ascertain administrative eligibility. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.

If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.

When the Alliance receives a referral for eligibility determination the following processes occur, although the ordering of the processes may vary according to individual cases:

1. Alliance CBAS team receives initial referral of a member to CBAS.

~~i. The Alliance acknowledges initial referral in writing to CBAS provider and to member within five (5) calendar days of initial referral.~~

~~ii.~~i. Out of Plan RN makes first attempt to schedule Face-to-Face assessment within 5 calendar days of initial referral.

a. the RN makes two additional attempts via telephone to schedule between five (5) and eight (8) calendar days of initial referral

b. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.

c. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

~~iii.~~ii. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:

a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

i. Denial of CBAS program:

a. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.

b. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.

c. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approval of CBAS program:

a. Eligibility determination is communicated to the member and her/his

authorized representative within two ~~one~~ (2~~1~~) business days.

b. Authorization to conduct Individual Plan of Care (IPC) is communicated to the member's chosen CBAS provider within one (1) business day of the decision.

At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

5. CBAS center staff:

i. Performs three (3) day multidisciplinary team assessment.

ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation

iii. Submits a Prior Authorization request to the Alliance.

6. The Alliance:

i. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.

a. If the Alliance cannot make a decision within five (5) working days of receiving the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.

b. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, ~~i~~Independent Medical R~~r~~eview, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day~~24 hours~~.

c. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approved services are authorized for a six-month period.

a. Member is notified within 2 Business Days~~48 hours~~ of authorization.

b. Center is notified within 1 Business Day~~24 hours~~ of authorization.

7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.

i. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in circumstances occurs that may require a change in the member's CBAS benefit.

ii. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

iii. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

~~iv. If the recurring prior authorization request is modified or the level of service is decreased, the Alliance conducts another face-to-face assessment with the member and the process repeats as specified above.~~

~~v.~~iv. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

a. The Member's name and ID number
b. The name(s) of the Member's Physician(s)
c. If applicable, the date of the Notice of Action denying authorization for CBAS was issued
d. If applicable, the date the CBAS benefit will be terminated
e. Specific information about the Member's current medical condition, treatments, and medications
f. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge
g. Contact information for the Member's case manager
h. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

~~vi.~~v. Communication and Coordination of Care

a. AAH will coordinate with the CBAS provider to ensure:
    - Timely exchange of the following coordination of care information:
    - Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
    - Clear communication pathways between the appropriate CBAS Provider and staff and AAH staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.
b. AAH will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in AAH policies and procedures related to CBAS.

DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the

Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the ~~California Bridge to Reform Waiver 11-W-00193/9, Special Terms and conditions, Paragraph 91,~~California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

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"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long Term Care

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RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 4/9/2024, 09/25/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

DHCS CBAS Contract, Exhibit A, Attachment 20.4

DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions

Health and Safety Code 1367.01

~~Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012~~

MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn-around-time.

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POLICY AND PROCEDURE

Policy Number	CM-009
Policy Name	Enhanced Care Management Program Infrastructure
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (AAH) leverages existing relationships and communications with our provider network to facilitate care planning, care coordination, and care transition coordination as stated in the Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Program Guide.

AAH's ECM is structured as a network which includes AAH contracted ECM Providers, and relationships with other Community-Based Organizations and providers to provide linkages to healthcare, community, and social support services.

The ECM Provider serves as the primary coordinator for overseeing the patient-centered care for assigned ECM eligible/enrolled members.

AAH will perform duties/responsibilities as outlined per the DHCS CalAIM Enhanced Care Management Program Guide.

AAH requires our subcontracted plans (delegates) use the same process for informing members, family member(s), guardian, caregiver and/or other authorized support person(s) about ECM, how to request ECM and that the status of the request is communicated back to inquiring party.

PROCEDURE

1.0 The ECM network will be developed and continually monitored to meet the following goals:

1.1 Ensure sufficient ECM funds are available to support care management at the point of care in the community.

1.2 Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available.
1.3 Leverage existing county and community provider care management infrastructure and experience.
1.4 Forge new relationships with community provider care-management entities.
1.5 Utilize community health workers in appropriate roles.

2.0 The goal of ECM includes:

2.1 Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based services & supports, palliative care, and social support needs, including housing;

2.1.1 In order to identify risks and improve member outcomes, the ECM Provider is responsible for conducting a Health Action Plan, defined as a comprehensive risk assessment and care plan, within ninety (90) calendar days of the member's enrollment into the ECM.

2.2 Reducing avoidable health costs, including hospital admissions/readmission, Emergency Department (ED) visits, and nursing facility stays.

2.2.1 AAH manages and monitors key metrics reports compiled by the AAH Analytics team. The ECM dashboard is distributed to the appropriate ECM Provider on a routine basis.

2.3 AAH performs the following duties/responsibilities:

2.3.1 AAH will inform the providers and entities who serve the Members of this Population of Focus as follows:

2.3.1.1 Inclusion of ECM information in Quarterly Provider Packets sent to providers either through mail or delivered in-person

2.3.1.2 Posting of ECM materials and announcements on the Alliance website

2.3.1.3 Instructions on to whom/how to initiate ECM referrals-(referral form) on Alliance website

2.3.1.4 Instructions on how to contact Alliance Case Management Department on the Alliance website

2.3.1.5 Newsletter on Alliance website

2.3.1.6 In addition, AAH will be hosting community-based stakeholder meetings to include nursing homes, home health agencies, Community Based Adult Services (CBAS) Providers, the Senior Services Coalition, Alameda County Health Care Services Agency (HCSA), and Centers for Independent Living.

2.3.1.7 Provide ongoing technical support for billing and reporting requirements.

2.3.1.8 Encourage providers to apply for IPP funding to facilitate network expansion and capacity building.

2.3.1.9 Through IPP funds, AAH as partnered with UCSF's THE Collective (Alameda County Training Development Unit) to provide ongoing soft skills development and additional training for providers.

2.3.2 Assigns ECM eligible members to ECM Providers

2.3.2.1 AAH Analytics team produces monthly eligibility lists based on defined criteria for each population of focus.

2.3.2.2 AAH Analytics team distributes eligibility lists across the network of ECM Providers

2.3.2.3 AAH also reviews referrals coming in from other AAH departments, ECM Providers, providers, members, and other entities serving adults living in the community who are at risk of Long-Term Care institutionalization and nursing facility residents transitioning to the community. Members may self-refer into ECM and/or dis-enroll at any time. AAH has a no wrong door policy. AAH will accept an ECM referral from PCPs, clinics, community & county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, CCS, foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

2.3.2.4 AAH uses a closed loop referral system for all ECM referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

2.3.2.4.1 For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.

2.3.2.4.2 Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.

2.3.3 Contracts with ECM Providers for provision of ECM services and ensures ECM Providers fulfill required duties and achieve ECM goals (See CM-013 ECM Oversight, Monitoring and Controls).

2.3.4 Notifies ECM Providers of inpatient admissions and ED visits through the following mechanisms:

2.3.4.1 Daily census reports distributed by the AAH Analytics team; includes the admission and discharge status.

2.3.4.2 AAH Utilization Management (UM), Case Management (CM) or ECM Staff outreach to ECM Provider staff through phone, email, or a combination.

2.3.4.3 AAH and ECM Providers access available data exchange platform(s), when possible.

2.3.5 Tracks and shares data with ECM Providers regarding each member's health history.

2.3.5.1 AAH Analytics team distributes relevant, available health history data to each ECM Provider within the eligibility list.

2.3.5.2 AAH ECM Clinical Staff and Analytics Staff support the ECM Providers with additional data on member's health histories, as needed.

2.3.6 Tracks and reports Centers for Medicare and Medicaid Services (CMS) required quality measures as outlined in DHCS guidelines.

2.3.7 Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported per DHCS guidelines.

2.3.8 Provides resources relating to ECM as needed.

2.3.9 Adds functionality to AAH Member Services Team and the AAH Nurse Advice Line.

2.3.9.1 AAH conducts ECM refresher trainings and comprehensive trainings on a regular cadence.

2.3.10 Receives payment from DHCS and disperses funds in a timely manner to ECM Providers through collection and submission of data by the ECM Provider, and through the contractual agreement made between AAH and the ECM Provider.

2.3.11 Establishes and maintains a data-sharing agreement with contracted providers with whom AAH shares ECM member health information which is compliant with all federal and state laws and regulations, including member's parent/guardian ECM related data sharing regulations. Contracted providers are expected to obtain and document member agreement and data sharing authorization. Contracted providers shall notify AAH of the members' parent/guardian authorization of data sharing authorization preferences. As part of the ECM Provider pre-certification process, AAH requires tools and processes for obtaining and managing member authorizations for the sharing of Personally Identifiable Information. In addition, the standard provider contract includes a Business Associate Agreement (BAA), which Providers will be required to follow to obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between AAH, ECM, ILOS, and other Providers involved in the provision of Member care. AAH conducts auditing and oversight of ECM Provider activities that includes the review of protection methods for Personally Identifiable Information.

2.3.12 Ensures timely access to services for ECM members, including follow-up with ECM members after discharge from an acute care setting.

2.3.13 Encourages participation by network primary and specialty providers who are not included formally on the ECM Providers multi-disciplinary care team but who are responsible for coordinating with the ECM Provider.

2.3.13.1 The AAH Provider Services Staff outreaches to all contracted primary care, specialty, and other community-based providers about ECM.

2.3.13.2 The AAH ECM Staff outreaches to contracted hospitals, skilled nursing facilities, and urgent care facilities.

2.3.14 Develops training tools for ECM Providers.

2.3.14.1 AAH coordinates in-person/virtual trainings with ECM Providers and additional webinars, as needed. AAH will continue to provide training and education through monthly learning collaboratives with ECM Providers. In addition, materials will be updated on the AAH Provider Portal and information will be included in the AAH Provider newsletter.

2.3.14.2 AAH ECM staff are available to provide technical assistance and training to ECM Providers as needed.

2.3.15 Partners with ECM Providers to develop reporting capabilities for ECM Providers using their available data/patient tracking systems.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
CM	Case Management
UM	Utilization Management
DHCS	Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 02/21/2023, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-009
Policy Name	Enhanced Care Management Program Infrastructure
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

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HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 02/21/2023, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-010
Policy Name	Enhanced Care Management – Member Identification and Grouping
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	8/17/2005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) is responsible for the development, implementation and distribution of requirements for the Enhanced Care Management (ECM) services and related activities to contracted entities, including member identification and risk grouping.

1.2 Member Identification: Members are identified through three methodologies:

1.2.1 ECM Eligibility List: AAH will generate a monthly ECM Eligibility List based on the defined criteria of the ECM Populations of Focus. Verification and analysis of the list will then be completed. The Eligibility List will be distributed to each ECM Provider with their assigned members.

1.2.2 Self-Referrals: Members may self-refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.2.3 Newly enrolled MCP Members who were receiving ECM through their previous Med-Cal Managed Care Plan: Members, Member's family or Authorized Representative (AR) may refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.3 Risk Grouping: Members confirmed by AAH as eligible for ECM are prioritized for outreach and engagement based on those that present the greatest opportunity for improvement from care management and reduction in avoidable utilization.

1.3.1 Prioritization will be accomplished through application of a tiering logic that risk stratifies the ECM population into two tiers corresponding to their level of priority, where High Tier is highest risk, and Low Tier is a combined medium and low risk.

1.3.2 A rate and payment structure will be developed and implemented that takes into consideration the increased ECM services experienced by the High Tier.

1.3.3 AAH will apply a prioritization framework to the list to help guide the ECM Providers in outreach efforts.

1.3.4 The tiering logic will be assessed by AAH for validity no less than annually and modified and as needed to maximize efficacy.

PROCEDURE

2.1 Member Identification: AAH identifies eligible members through the following mechanisms:

2.1.1 AAH generates a list of ECM eligible members on a monthly basis.

2.1.1.1 AAH verifies AAH Member eligibility and excludes disenrolled Members.

2.1.1.2 Data sources used to identify eligible ECM members by Population of Focus include the following:

Data Source	Resourced From
Enrollment data	Member enrollment data from HealthSuite (AAH claims/eligibility system) including member address information, and 1915(c) waiver wait lists when available
Encounter data	Encounter data including pregnant/postpartum data from AAH providers stored in AAH Datawarehouse
Utilization/claims data	AAH claims data from HealthSuite including pregnant/postpartum data; Plan Data Feed
Pharmacy data	AAH claims data from HealthSuite, historical pharmacy data extracts from AAH's Pharmacy Benefits Manager, current pharmacy data extracts from DHCS (Service Dates 1/1/2022 forward)
Laboratory data	Encounter data from AAH laboratory providers stored in AAH Datawarehouse
SMI/SUD data, as available	Alameda County Behavioral Health (ACBH) utilization/encounter data for SMI (Note: SUD data not available without member consent)

Screening or assessment data	AAH Care Management (CM) assessment and Utilization Management (UM) review data from TruCare (AAH care management system)
Information about Social Determinants of Health, including standardized assessment tools including Protocols for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classifications of Diseases, Tenth Revision (ICD-10) codes	ICD-10 codes from AAH and ACBH encounter/claims data
Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), available data from the education system	HMIS and Targeted Case Management (TCM) data from Alameda County Social Health Information Exchange (SHIE); Minimum Data Set (MDS) assessment
Clinical information on physical and/or behavioral health	CareAnalyzer (AAH population health analytics tool) data for diagnosis groupings based on Johns Hopkins ACG System and risk/utilization measures.
Risk stratification information for Members under 21 years of age in Contractor's with Whole Child Model (WCM) programs	Not Applicable for AAH
Results from any available Adverse Childhood Experience (ACE) screening	Positive results from an Adverse Childhood Experiences (ACEs) screening, when available
School absentee or truancy information	When available

2.1.1.3 AAH consolidates the data sources into their reporting databases and develops individual criteria/logic for each ECM Population of Focus to identify eligible members. ECM Population of Focus criteria is based on the population definitions provided by the Department of Health Care Services (DHCS).

2.1.1.4 As new populations are implemented and/or new data sources are identified, AAH will review and evaluate each data source to determine their impact on the identification process. Any new data sources deemed to have an impact on the identification criteria will be incorporated into the existing identification logic.

2.1.1.5 Any exclusion and/or non-duplication criteria as outlined in the DHCS ECM Program Guide will be incorporated into the identification logic, when applicable, and pending data source availability.

2.1.2 AAH applies tiering logic to the final AAH ECM eligibility list and assignment logic to match Members with the appropriate ECM Provider. Assignment to ECM Providers will be determined using factors including the Member's past medical and mental health history, location and history of working with the provider. In addition, alignment of specific member needs to ECM Provider expertise and skillset will be taken into consideration. If a member's main driver is Serious Mental Illness (SMI), the member will be assigned to an ECM provider who specializes in SMI. California Children's Services (CCS) Providers are not currently contracted to provide ECM. Should CCS Providers join the ECM Provider network, AAH will assign qualifying members to ECM CCS Providers. AAH takes into consideration Provider feedback regarding the appropriateness of the ECM assignment, when requested, and will take action, as necessary. Any feedback received from prospective ECM Provider, PCP, and ECM Member will be incorporated into the appropriateness of the assignment.

2.1.3 AAH submits the tiered ECM eligibility list of assigned members via Secure File Transfer Protocol (SFTP) to each ECM Provider within ten (10) days of determining ECM eligibility to conduct outreach and engagement activities.

2.1.4 A Provider, health plan staff, ECM staff, other non-provider community entity, the Member him/herself, or a Member's caregiver/family may refer a Member to AAH for ECM services. AAH will then connect the Member with an ECM Provider to evaluate for eligibility for ECM services.

2.1.4.1 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929 (TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929 (TTY) after hours to inquire about ECM.

2.1.4.2 For subcontracted entities (delegates), the same process for referring/requesting ECM authorization applies as directed above.

2.1.5 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data, newly enrolled Members who were receiving ECM through their previous MCP will continue to receive ECM services through AAH.

2.1.5.1 When AAH becomes aware of such a request, AAH will automatically authorize the Member for ECM services for 12 months.

2.1.5.2 AAH will outreach to the Member's previous MCP, the Member and/or previous ECM Provider to obtain access to the Member's Care Management Plan to mitigate any gaps in care. AAH will share the Care Management Plan with the new ECM Provider and assist with a warm hand-off between ECM Providers, when necessary.

2.1.5.3 When available, AAH will review historical utilization data using a 90-day look-back period to identify Members who have received ECM.

2.1.5.4 These Members will be reassessed by the ECM Provider, prior to the end of the authorized period, to determine the appropriate level of care management or coordination of services, whether ECM or a lower level of care management or coordination. ECM Providers will assess Members using the ECM Graduation Bundle. (See *CM-011 Enhanced Care Management & Transitions of Care Attachment A*)

2.1.5.5 AAH requires subcontracted plans (delegates) use the same process for automatically authorizing newly enrolled members who were receiving ECM through their previous Medi-Cal managed care plan.

2.2 Risk Grouping: AAH will apply a Risk Grouping methodology as follows:

2.2.1 Initial administrative data tiering will be performed on the entire ECM Universe.

2.2.1.1 Claims, encounters and supplemental data will be used to identify "high risk" members defined as meeting at least one of the following criteria:

2.2.1.1.1 Four (4) or more Emergency Department (ED) visits in a 12-month period.

2.2.1.1.2 Two (2) or more unplanned inpatient admits or Skilled Nursing Facility (SNF) stays in a 12-month period.

2.2.1.1.3 Members meeting the homeless Population of Focus

2.2.1.1.4 Members meeting the Serious Mental Illness (SMI) and/or the Substance Use Disorder (SUD) Population of Focus.

2.2.1.2 The ECM eligible members identified through this process will fall into the High Tier.

2.2.1.3 High Tier members will be paid at a rate and payment structure that takes into consideration the increased ECM services experienced by the High Tier members. ECM Providers enrolling High Tier members will be required to have weekly encounters and at least one in-person encounter a month to be eligible for the enhanced rate. In-person meetings may be temporarily suspended during a declared public health emergency; however, alternative means of communication with members should be employed to contact members during this time.

2.2.1.4 The tiering logic for High Tier will be assessed by AAH for validity no less than annually and modified as needed.

2.2.1.5 All other ECM eligible members will fall into the Low Tier.

2.2.1.6 ECM Providers enrolling Low Tier members will be required to have monthly encounters.

2.2.2 AAH will provide the High/Low Tiering in the monthly Member Information file. The High/Low Tiers will help guide the ECM Providers in their outreach efforts for their ECM eligible.

2.2.3 Those members with the highest tier will be placed higher on the priority list within the respective Tiers and ECM Providers will be asked to prioritize outreach to those members.

2.2.3.1 All members within a Tier will be paid at the same rate.

2.2.3.2 The tiering logic for the Low Tier will be assessed by AAH for validity at least annually and modified and as needed.

2.3 Member assignment is documented in the eligibility lists distributed to each ECM Provider. In addition, member assignment is also stored in the AAH databases for reporting, viewing, and historical purposes.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
SNF	Skilled Nursing Facility
TCM	Targeted Case Management
SMI	Serious Mental Illness
PCP	Primary Care Provider
ACG	Adjusted Clinical Groups
RUB	Resource Utilization Band
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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification

CM-010 Enhanced Care Management – Member Identification and Grouping

HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 03/22/2022, 05/23/22, 06/20/2022 02/03/2023, 02/08/2023, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-010
Policy Name	Enhanced Care Management – Member Identification and Grouping
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	8/17/2005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	~~10/19/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) is responsible for the development, implementation and distribution of requirements for the Enhanced Care Management (ECM) services and related activities to contracted entities, including member identification and risk grouping.

1.2 Member Identification: Members are identified through three methodologies:

1.2.1 ECM Eligibility List: AAH will generate a monthly ECM Eligibility List based on the defined criteria of the ECM Populations of Focus. Verification and analysis of the list will then be completed. The Eligibility List will be distributed to each ECM Provider with their assigned members.

1.2.2 Self-Referrals: Members may self-refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.2.3 Newly enrolled MCP Members who were receiving ECM through their previous Med-Cal Managed Care Plan: Members, Member's family or Authorized Representative (AR) may refer into ECM at any time by contacting AAH Member Services, a contracted ECM Provider, or any AAH Staff.

1.3 Risk Grouping: Members confirmed by AAH as eligible for ECM are prioritized for outreach and engagement based on those that present the greatest opportunity for improvement from care management and reduction in avoidable utilization.

1.3.1 Prioritization will be accomplished through application of a tiering logic that risk stratifies the ECM population into two tiers corresponding to their level of priority, where High Tier is highest risk, and Low Tier is a combined medium and low risk.

1.3.2 A rate and payment structure will be developed and implemented that takes into consideration the increased ECM services experienced by the High Tier.

1.3.3 AAH will apply a prioritization framework to the list to help guide the ECM Providers in outreach efforts.

1.3.4 The tiering logic will be assessed by AAH for validity no less than annually and modified and as needed to maximize efficacy.

PROCEDURE

2.1 Member Identification: AAH identifies eligible members through the following mechanisms:

2.1.1 AAH generates a list of ECM eligible members on a monthly basis.

2.1.1.1 AAH verifies AAH Member eligibility and excludes disenrolled Members.

2.1.1.2 Data sources used to identify eligible ECM members by Population of Focus include the following:

Data Source	Resourced From
Enrollment data	Member enrollment data from HealthSuite (AAH claims/eligibility system) including member address information, and 1915(c) waiver wait lists when available
Encounter data	Encounter data including pregnant/postpartum data from AAH providers stored in AAH Datawarehouse
Utilization/claims data	AAH claims data from HealthSuite including pregnant/postpartum data; Plan Data Feed
Pharmacy data	AAH claims data from HealthSuite, historical pharmacy data extracts from AAH's Pharmacy Benefits Manager, current pharmacy data extracts from DHCS (Service Dates 1/1/2022 forward)
Laboratory data	Encounter data from AAH laboratory providers stored in AAH Datawarehouse
SMI/SUD data, as available	Alameda County Behavioral Health (ACBH) utilization/encounter data for SMI (Note: SUD data not available without member consent)

Screening or assessment data	AAH Care Management (CM) assessment and Utilization Management (UM) review data from TruCare (AAH care management system)
Information about Social Determinants of Health, including standardized assessment tools including Protocols for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classifications of Diseases, Tenth Revision (ICD-10) codes	ICD-10 codes from AAH and ACBH encounter/claims data
Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), available data from the education system	HMIS and Targeted Case Management (TCM) data from Alameda County Social Health Information Exchange (SHIE); Minimum Data Set (MDS) assessment
Clinical information on physical and/or behavioral health	CareAnalyzer (AAH population health analytics tool) data for diagnosis groupings based on Johns Hopkins ACG System and risk/utilization measures.
Risk stratification information for Members under 21 years of age in Contractor's with Whole Child Model (WCM) programs	Not Applicable for AAH
Results from any available Adverse Childhood Experience (ACE) screening	Positive results from an Adverse Childhood Experiences (ACEs) screening, when available
School absentee or truancy information	When available

2.1.1.3 AAH consolidates the data sources into their reporting databases and develops individual criteria/logic for each ECM Population of Focus to identify eligible members. ECM Population of Focus criteria is based on the population definitions provided by the Department of Health Care Services (DHCS).

2.1.1.4 As new populations are implemented and/or new data sources are identified, AAH will review and evaluate each data source to determine their impact on the identification process. Any new data sources deemed to have an impact on the identification criteria will be incorporated into the existing identification logic.

2.1.1.5 Any exclusion and/or non-duplication criteria as outlined in the DHCS ECM Program Guide will be incorporated into the identification logic, when applicable, and pending data source availability.

2.1.2 AAH applies tiering logic to the final AAH ECM eligibility list and assignment logic to match Members with the appropriate ECM Provider. Assignment to ECM Providers will be determined using factors including the Member's past medical and mental health history, location and history of working with the provider. In addition, alignment of specific member needs to ECM Provider expertise and skillset will be taken into consideration. If a member's main driver is Serious Mental Illness (SMI), the member will be assigned to an ECM provider who specializes in SMI. California Children's Services (CCS) Providers are not currently contracted to provide ECM. Should CCS Providers join the ECM Provider network, AAH will assign qualifying members to ECM CCS Providers. AAH takes into consideration Provider feedback regarding the appropriateness of the ECM assignment, when requested, and will take action, as necessary. Any feedback received from prospective ECM Provider, PCP, and ECM Member will be incorporated into the appropriateness of the assignment.

2.1.3 AAH submits the tiered ECM eligibility list of assigned members via Secure File Transfer Protocol (SFTP) to each ECM Provider within ten (10) days of determining ECM eligibility to conduct outreach and engagement activities.

2.1.4 A Provider, health plan staff, ECM staff, other non-provider community entity, the Member him/herself, or a Member's caregiver/family may refer a Member to AAH for ECM services. AAH will then connect the Member with an ECM Provider to evaluate for eligibility for ECM services.

2.1.4.1 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929 (TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929 (TTY) after hours to inquire about ECM.

2.1.4.2 For subcontracted entities (delegates), the same process for referring/requesting ECM authorization applies as directed above.

2.1.5 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data, newly enrolled Members who were receiving ECM through their previous MCP will continue to receive ECM services through AAH.

2.1.5.1 When AAH becomes aware of such a request, AAH will automatically authorize the Member for ECM services for 12 months.

2.1.5.2 AAH will outreach to the Member's previous MCP, the Member and/or previous ECM Provider to obtain access to the Member's Care Management Plan to mitigate any gaps in care. AAH will share the Care Management Plan with the new ECM Provider and assist with a warm hand-off between ECM Providers, when necessary.

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2.1.5.4 These Members will be reassessed by the ECM Provider, prior to the end of the authorized period, to determine the appropriate level of care management or coordination of services, whether ECM or a lower level of care management or coordination. ECM Providers will assess Members using the ECM Graduation Bundle. (See *CM-011 Enhanced Care Management & Transitions of Care Attachment A*)

2.1.5.5 AAH requires subcontracted plans (delegates) use the same process for automatically authorizing newly enrolled members who were receiving ECM through their previous Medi-Cal managed care plan.

2.2 Risk Grouping: AAH will apply a Risk Grouping methodology as follows:

2.2.1 Initial administrative data tiering will be performed on the entire ECM Universe.

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2.2.1.1.4 Members meeting the Serious Mental Illness (SMI) and/or the Substance Use Disorder (SUD) Population of Focus.

2.2.1.2 The ECM eligible members identified through this process will fall into the High Tier.

2.2.1.3 High Tier members will be paid at a rate and payment structure that takes into consideration the increased ECM services experienced by the High Tier members. ECM Providers enrolling High Tier members will be required to have weekly encounters and at least one in-person encounter a month to be eligible for the enhanced rate. In-person meetings may be temporarily suspended during a declared public health emergency; however, alternative means of communication with members should be employed to contact members during this time.

2.2.1.4 The tiering logic for High Tier will be assessed by AAH for validity no less than annually and modified as needed.

2.2.1.5 All other ECM eligible members will fall into the Low Tier.

2.2.1.6 ECM Providers enrolling Low Tier members will be required to have monthly encounters.

2.2.2 AAH will provide the High/Low Tiering in the monthly Member Information file. The High/Low Tiers will help guide the ECM Providers in their outreach efforts for their ECM eligible.

2.2.3 Those members with the highest tier will be placed higher on the priority list within the respective Tiers and ECM Providers will be asked to prioritize outreach to those members.

2.2.3.1 All members within a Tier will be paid at the same rate.

2.2.3.2 The tiering logic for the Low Tier will be assessed by AAH for validity at least annually and modified and as needed.

2.3 Member assignment is documented in the eligibility lists distributed to each ECM Provider. In addition, member assignment is also stored in the AAH databases for reporting, viewing, and historical purposes.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
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CM-018 Enhanced Care Management – Member Notification

CM-010 Enhanced Care Management – Member Identification and Grouping

HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 03/22/2022, 05/23/22, 06/20/2022 02/03/2023, 02/08/2023, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-011
Policy Name	Enhanced Care Management – Care Management & Transitions of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	02/01/2000
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Outreach and engagement are ensured and Enhanced Care Management (ECM) services are prioritized according to risk grouping tiers by ECM Providers. ECM Members are thoroughly assessed, including complex medical conditions, behavioral conditions and/or social needs. Health Action Plans (HAPs) are developed to assist in the management of the Member's needs including housing (instability, homelessness), Transition of Care support and Referral tracking and follow-up. Improving Quality of Care, patient safety and prevention of unnecessary hospital or emergency department admissions/visits are a key focus.

PROCEDURE

1.0 Pre-enrollment Member Outreach and Engagement

1.1 Each ECM Provider is responsible for developing and implementing outreach and engagement strategies for the purpose of enrolling Members into ECM. Outreach and engagement efforts are made according to Members' tiering level, where High Tier Members have priority, followed by Low Tier Members.

1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible to develop and implement an outreach and engagement plan for each eligible ECM Member. Lead Care Managers who serve adults living in the community who are risk of Long Term Care (LTC) institutionalization

and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (Per 42 CFR § 438.208 the care plan must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)) for members with long-term services and supports (LTSS) needs. If the ECM Member contacts the ECM Provider or AAH to requests a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager. This process is the same for subcontracted plans (delegates).

1.2.1 Care team assignments for conducting outreach and enrollment should be customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location and other characteristics, as appropriate.

1.2.2 Individuals assigned to conduct outreach and engagement for enrollment and ongoing engagement may include, but are not limited to, community health workers and care coordinators.

1.2.3 Engagement plans are individualized using various approved strategies most appropriate for each Member, including provisions for Members experiencing homelessness.

1.2.4 Outreach and engagement plans take into account any background information available from care records, claims, or other providers regarding physical and behavioral health conditions, history of trauma, Member's language and cultural preferences, health literacy, preferred modes of communication (e.g., phone versus text), housing and work history, current housing status other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when/where/how the Member has sought care in the past.

1.2.5 Active outreach strategies may include but not be limited to:

1.2.5.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

1.2.5.2 With member permission, direct communications with Members by letter, email, texts, telephone;

1.2.5.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

1.2.5.4 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

1.2.6 Outeach efforts for high priority members will progress over ninety (90) days from the ECM Provider's receipt of the attributed ECM Member list. Outreach efforts will consist of:

1.2.6.1 Assigned Members in the High Tier will receive a minimum of every other week outreach contacts/attempts.

1.2.6.2 Assigned Members in the Low Tier will receive a minimum of monthly outreach contacts/attempts.

1.2.7 All attempts to contact will be documented within the ECM Provider's care management platform or equivalent platform.

1.2.7.1 During initial contact by an ECM Provider care team member conducting outreach, each Member is fully informed about ECM and terms of their participation, in accordance with this policy, and

asked to either consent or decline to participate in ECM. A successful outreach contact shall consist of the following:

1.2.7.1.1 Confirm Member eligibility for ECM.

1.2.7.1.2 Verify if Member is receiving any care management/coordination services with any other program.

1.2.7.1.2.1 If the Member self-reports in the negative, they can be enrolled in ECM.

1.2.7.1.2.2 If the Member confirms enrollment in another program, they will be advised to choose only one of the programs.

1.2.7.1.3 As Members are reassessed, the ECM Provider team will again verify that the Member is not enrolled in duplicate care management/care coordination services or programs.

1.2.7.2 Document the Member's verbal or written consent in the care management record.

1.2.7.3 Notify and coordinate care with the Member's PCP and relevant specialty providers of Member's enrollment in ECM.

1.2.7.4 Either initiate or plan to complete the HAP with Member.

1.2.7.5 If the Member declines to participate in ECM:

1.2.7.5.1 Member is informed regarding continuing care with their PCP and obtaining assistance with coordination, as appropriate.

1.2.7.5.2 Member is informed that they may re-engage and receive ECM services at any time in the future as long as he or she continues to meet ECM eligibility requirements.

1.2.7.5.3 Declination is documented in the ECM Provider's care management platform or system of record.

1.2.7.6 AAH monitors, documents, and reports the progress and results of all ECM activities required to be reported to the Department of Health Care Services (DHCS), in accordance with provisions of this policy and any DHCS Program Guide.

2.0 Health Action Plan

2.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP (See Related Workflow Documents or Other Attachments).

2.2 ECM Assessment

2.2.1 The ECM Assessment is administered to provide a deeper base of knowledge needed to address complex medical conditions, longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

2.2.1.1 Physical health;

2.2.1.2 Mental health;

2.2.1.3 Substance Use Disorder (SUD);

2.2.1.4 Community-based Services;

2.2.1.5 Palliative care;

2.2.1.6 Trauma-informed care needs;

2.2.1.7 Social Supports;
2.2.1.8 Housing and other Social Determinants of Health; and
2.2.1.9 Utilization

2.2.2 Addressing palliative care and trauma informed care needs

2.2.2.1 The ECM Assessment addresses the following palliative care domains: pain; difficulty taking medications; physical function; social connections; and advance (directive) planning. The Alliance incorporates the elements of palliative care into the ECM Assessment without using the word "palliative."

2.2.2.2 The ECM Assessment addresses the following trauma-informed care domains: safety, mental health, substance use disorder, pain, utilization, and disease burden. The Alliance incorporates the components of trauma-informed care into the ECM Assessment without using the word, "trauma" and uses open-ended questions designed to elicit responses that could include experiences considered to be traumatic.

2.2.2.3 Recognizing that palliative care and trauma-informed-care may be new skill sets for ECM Provider staff, trainings to address and improve palliative care and trauma-informed care assessments will be regularly offered to ECM Providers.

2.2.3 ECM Providers make multiple efforts to contact newly enrolled ECM Members to conduct the ECM Assessment which will be repeated yearly and with any transition in care or other major event.

2.2.4 Following Member consent to enroll, Members identified as higher risk will be prioritized for the outreach and engagement to conduct and complete the ECM Assessment.

2.2.5 For the High Tier priority engagement group, ongoing attempts to contact occurs weekly using multiple modalities such as phone, email, and text (per the Member's documented preference) and at varying times of day and evening, for up to ninety (90) days.

2.2.6 For the Low Tier group, ongoing attempts to contact occurs monthly using multiple modalities and times of day and evening, for up to ninety (90) days.

2.2.7 If unable to contact the Member by phone or mail, every avenue is researched to secure a valid phone number (e.g. the PCP office, specialty care provider office, a vendor where durable medical equipment is rented from, current pharmacy used, or data available on other data exchange platforms, etc.).

2.2.8 The ECM Provider will document all contact attempts in their care management platform or system of record.

2.2.9 To facilitate communication among the Member's health care Providers, the completed ECM Assessment is made available to the entire ECM Provider team and the Member's PCP.

2.2.10 AAH ECM Providers will track, trend, monitor, and report ECM Assessment administration and reassessment practices for all eligible members.

2.3 Care Plan

2.3.1 Once the ECM Assessment is completed, the designated ECM Provider team member develops the Care Plan for each Member enrolled in ECM

services in collaboration with the Member, caregiver, and other members of the ECM Provider team.

2.3.2 The designated ECM Provider team member works with the Member to develop and prioritize goals according to the Member's priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal. Members have the opportunity to be involved in the development, review, and approval of the Care Plan and any amendments to the Care Plan, as appropriate.

2.3.3 The Care Plan is developed using the ECM Assessment data as well as other information available from various sources such as utilization data, pharmacy data, or notes from any AAH Care Management (CM) activities.

2.3.4 The Care Plan will include, but is not limited to, the following elements, as appropriate:

- 2.3.4.1 Language and communication preferences;
- 2.3.4.2 Risk level or complexity tier;
- 2.3.4.3 Housing status;
- 2.3.4.4 Care team supports, including contact information;
- 2.3.4.5 Emergency Department (ED)/hospital utilization;
- 2.3.4.6 Medications and dosage;
- 2.3.4.7 Any care needs identified on the ECM Assessment pertaining to chronic physical condition, behavioral health status including cognitive functions, developmental health and dementia, trauma-informed care, palliative care needs, and specific goals and action plan;
- 2.3.4.8 Self-management goals, including barriers to success, interventions, and goal status;
- 2.3.4.9 Timeframes for reassessment and ECM Provider follow-up frequency;
- 2.3.4.10 Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);
- 2.3.4.11 Care coordination and social support needs such as arranging transportation, obtaining appointments, referral tracking and status updates (including housing referrals), coordinating interpreter services, and educating on the importance of preventative services.

2.3.5 The HAP is accessible to all members of the care team:

- 2.3.5.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.
- 2.3.5.2 The PCP will be given the Member's HAP.
- 2.3.5.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

2.3.6 Quarterly, or more frequently if needed, the ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status or health care needs and/or according to the HAP follow up plan. A clinician at the ECM Provider reviews the HAP. AAH clinician ensures that appropriate ECM clinician has provided oversight to ensure the HAP is maintained and updated as appropriate

through quarterly audits.

2.3.6.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission, discharge or ED visit. This will alert them to contact the Member, as appropriate, to review the current HAP and make changes as necessary.

2.3.6.2 The ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.

2.3.6.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met, or is no longer applicable.

2.3.6.4 The HAP will be completed within ninety (90) days of ECM enrollment.

3.0 Member Ongoing Engagement and Care Management Services

3.1 ECM Provider team members provide ongoing care management support in person and telephonically at a frequency determined by the Member's complexity (Tier level) and desired level of involvement in ECM.

3.2 The ECM Lead Care Manager serves as the primary point of contact and supports activities provided by ECM Providers which include, but are not limited to:

3.2.1 Assessing and managing Members using evidence-based clinical protocols and resources;

3.2.2 Ensuring completion of HAP within specified timeframe;

3.2.3 Documenting Member's choice of caregiver or family/support persons and assisting Members and chosen family/support persons with access to appropriate resources;

3.2.4 Assisting Members and chosen family/support persons with scheduling appointments;

3.2.5 Tracking and monitoring internal and external referrals;

3.2.6 Developing and communicating self-management plans with input from the Member and caregiver(s)/family, as well as helping the member to identify and build on successes and potential family and/or support networks;

3.2.7 Providing appropriate, timely, and actionable Member education to improve self-management skills;

3.2.8 Empowering Members to enhance self-management using Motivational Interviewing techniques;

3.2.9 Using problem-based, comprehensive case planning, with measurable, prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments;

3.2.10 Providing care management that is Member-centric and culturally aware;

3.2.11 Interacting with Members and family and / or support persons from a holistic perspective, promoting collaboration and coordination, through all levels of the health care continuum including physical and behavioral health programs, pharmaceutical management, and community-based programs;

3.2.12 Monitoring and supporting treatment adherence (including medication management and reconciliation);

3.2.13 Assisting in attainment of the Member's goals as described in the HAP;

3.2.14 Encouraging the Member's decision-making and continued participation in ECM; and

3.2.15 Accompanying Members to appointments, as needed.

3.3 AAH ensures that the ECM Member's acuity will be the basis for the appropriate provision of ECM services by the ECM Provider. Members in the higher acuity risk groupings (tiers) will receive more intensive ECM services at a higher frequency.

3.3.1 High Risk (High Tier)

3.3.1.1 Attempt weekly contacts with the Member and, at a minimum, one in-person meeting per month. The in-person meeting per month may be temporarily suspended during a declared public health emergency; however, alternative means of communication with the Member should be employed to contact the Member during this time including secure teleconferencing and telehealth visits;

3.3.1.2 On-going communication with PCP regarding HAP updates and information-sharing;

3.3.1.3 Weekly, systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member's HAP, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their Care Plan; and

3.3.1.4 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

3.3.2 Low/Medium Risk (Low Tier)

3.3.2.1 Attempt monthly contacts with the Member;

3.3.2.2 ECM Provider staff can utilize a combination of telephonic and face-to-face encounters, based on the Member's preference, and as documented in the HAP. In-person meeting may be temporarily suspended during a declared public health emergency; however, alternative means of communication with member should be employed to contact member during this time including secure teleconferencing and telehealth visits.

3.3.2.3 On-going communication with PCP regarding HAP updates and information sharing;

3.3.2.4 Periodic systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member HAP's, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their care plan; and

3.3.2.5 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

4.0 Housing

4.1 ECM Members in need of housing services may be identified as follows:

4.1.1 ECM Providers conduct an ECM Assessment upon enrollment, annually, and with any change in status. The ECM Assessment includes questions that identify Members' homelessness or housing instability concerns.

4.1.2 Care team may be alerted to Members' housing concerns through the regular course of providing comprehensive care management services.

4.2 Members experiencing homelessness or housing instability will include goals

related to housing on their HAP. Goals may address:

4.2.1 Housing navigation;
4.2.2 Transitional support;
4.2.3 Tenancy support;
4.2.4 Assistance in finding permanent housing.
4.2.4.1 Referrals to housing navigation is a component of the ECM Provider care coordinator's functions.

4.3 AAH will provide the following support to ECM Providers:
4.3.1 Cultivate relationships with local housing agencies including permanent housing providers;
4.3.2 Cultivate relationships with homeless service providers;
4.3.3 Provide advocacy for Members through housing agencies and coalitions; and
4.3.4 Partner with Alameda County Health Care Services Agency (HCSA) and Corporation for Supportive Housing to create and provide educational offerings and technical assistance around housing navigation and tenancy supports, as needed.

5.0 Referral Management

5.1 Referral management is a component of the ECM Provider care coordinator's primary responsibilities. The ECM Provider care coordinator will track, monitor and provide referral coordination for all new, pending or completed referrals captured within the web-based care management platform or equivalent platform.
5.1.1 The ECM Assessment is the opportunity to gather and document relevant information regarding a member's needs, including medical health, behavioral health, palliative care, and social needs.
5.1.2 A member-centered plan of care is generated from the ECM Assessment which includes referrals agreed to by the ECM Member. These referrals may link ECM Members to medical specialty care, primary care, behavioral health, long term care services, palliative care, housing, community supports and any community resources which address the Member's needs.
5.1.3 Referrals may be placed to various services and appropriate community agencies via fax, telephone, in person or through secure electronic methods.
5.1.4 ECM Providers ensure that referrals were received and processed by the receiving agencies or providers, track whether services were received by the ECM Member and document the outcomes of the referrals.
5.1.5 Referrals will be followed up by phone, fax, in person or via secure electronic pathways, at scheduled intervals, to ensure that a referral has been completed and the ECM Member appropriately linked to services.

5.2 Referral and transition coordination include the following activities:
5.2.1 Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to internal or external referrals;
5.2.2 Review details and expectations about the referral with the Member and/or caregivers;
5.2.3 Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs, as appropriate, to referral source(s);

5.2.4 Assist Members in problem-solving potential barriers (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);
5.2.5 Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;
5.2.6 Remind patients of scheduled appointments based on the Member's preference and as documented in the HAP;
5.2.7 Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within specified timeframe, have cancelations, missed appointments, or other reasons for an incomplete referral;
5.2.8 Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and
5.2.9 Ensure the Member's health record is up to date with information on specialist consults, hospital summaries, diagnostic results, ED visits and community organization information related to the health of the Member.

6.0 Transitions of Care
6.1 AAH collaborates with ECM Provider staff to coordinate care across all healthcare settings, providers, and services to assure continuity of care.
6.2 ECM Providers, in partnership with AAH, continuously work with all facilities to ensure that Members are receiving comprehensive quality care in the least restrictive setting.
6.3 AAH ensures that ECM Providers have access to daily hospital admission, discharge and ED visit information for ECMMembers.
6.4 Member engagement and Transition of Care (TOC) activities begin during ED visit or hospital admission, when possible.
6.4.1 Upon notification of an ED visit or inpatient hospital admission, the ECM Provider care coordinator begins transition activities for ECM Members. Activities include, but are not limited to:
6.4.1.1 Engaging with the Member during their ED visit or hospitalization, if possible;
6.4.1.2 Engaging with the Member within 48 hours of their ED visit or hospital discharge;
6.4.1.3 Reviewing discharge plan and medication changes;
6.4.1.4 Updating HAP;
6.4.1.5 Referral management and coordination support; and
6.4.1.6 Scheduling timely follow-up appointment(s) with the Member's PCP and specialists, as appropriate.
6.4.1.6.1 Includes arranging transportation for transition care and to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policies and procedures.
6.4.1.7 Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.
6.4.1.7.1 When possible, provide transition support to permanent housing.
6.4.1.8 The ECM Provider team contacts the Member to monitor their status before, during and after a transition of care, when possible.
6.4.2 The ECM Provider care coordinator will update the ECM Provider team, or

the multidisciplinary care team, who will assist with the coordination and delivery of services or schedule case conferences to discuss supportive measures needed, changes to the HAP, and discussions to prevent future utilization.

6.4.3 ECM Providers have ongoing communication with facilities to monitor Members' needs and the services provided to them.

6.4.3.1 AAH prevents readmissions by utilizing evidence-based best practices for Transitions of Care and encouraging ECM Providers to follow the same. AAH tracks readmissions via an ECM-specific dashboard that is shared with ECM Providers on a regular basis.

7.0 Member Transition to Lower Level of Care/Disenrollment

7.1 ECM Provider teams will continue to reassess the Member's risk status level and programmatic appropriateness.

7.1.1 Members transitioning to ECM from the Health Homes Program (HHP) or Whole Person Care (WPC) Pilot will be reassessed within a period of six (6) months to determine the most appropriate level of services for each Member, whether in ECM or a lower level of care coordination.

7.1.2 When Members have experienced a 6-month period of stability, defined by well managed clinical measures, no hospital or ED utilization and have successfully met their self-management goals on the HAP, they are ready to transition to a lower level of care and disenroll or "graduates" from ECM.

7.1.3 If a Member consented and engaged in ECM but has had no active participation for ninety (90) days, despite ongoing outreach and engagement efforts by the ECM Provider team, the Member will be disenrolled.

7.1.4 If a Member chooses to disenroll for any reason, the Member will be disenrolled.

7.1.5 If a Member is now participating in another program excluding them from ECM eligibility, the Member may choose the alternate program and be disenrolled from ECM.

7.1.6 The disenrollment reason will be documented in the web-based care management platform or equivalent platform.

7.1.7 The ECM provider will notify AAH when the member is ready to transition to a lower level of care. The ECM Provider will use the Alliance Enhanced Care Management Graduation Bundle (Attachment A) to determine when an ECM Member is ready for graduation and ready to transition to a lower level of care. AAH will not be determining the member's readiness for graduation but will follow the recommendation of the ECM Provider who is providing the direct services. AAH will follow the standard Grievance & Appeals process when a member disputes ECM graduation and transition to a lower level of care.

7.1.8 The provider will provide a warm handoff, when appropriate, to the receiving lower level Care Management provider. Lower level Care Management may include programs at the ECM Provider, or other community Care Management entities, including AAH telephonic Care Management. If the ECM Provider has difficulty locating an appropriate lower level of care provider, the Alliance will assist in identifying an appropriate provider, including acceptance of the member into the AAH

telephonic care management program. AAH will work with ECM Provider to graduate the member and transition to a lower level of care when needed.

7.2 The process ECM Providers are expected to use to notify the Alliance when discontinuation criteria are met is through the monthly submission of the DHCS Member Information File. This file includes Disenrollment Reason codes notifying the Plan of discontinuation of delivery (e.g. graduation, disenrollment, unwilling to engage, provider unable to connect after multiple attempts).Upon notification from the ECM Provider, AAH will issue a Notice of Action (NOA) to Members disenrolled from ECM for specific situations. AAH will send the NOA to the Member, ECM provider and PCP within thirty (30) days after the effective date of ECM disenrollment. AAH will send a NOA to the Member, the ECM Provider, and the Member's PCP (if the ECM Provider is not the Member's PCP) if:

- 7.2.1 The Member develops a change in eligibility such as an exclusionary condition;
- 7.2.2 The Member's eligible chronic condition(s) become well-managed (for six consecutive months);
- 7.2.3 The Member has met all care plan goals;
- 7.2.4 The Member is ready to transition to a lower level of care;
- 7.2.5 The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
- 7.2.6 A Member consents and enrolls, but there is no documented active participation for ninety (90) days despite outreach and engagement efforts as part of care management.
- 7.2.7 When ECM services are discontinued; the Member or the ECM Provider may request the member be transitioned to a lower level of care management. AAH will work with the ECM Provider to complete a warm handoff to AAH's telephonic Case Management or to a community-based case management program.

7.3 AAH will not send a NOA to a member who chooses to disenroll from ECM.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
NOA	Notice of Action
ECM	Enhanced Care Management
HAP	Health Action Plan
TOC	Transition of Care
WPC	Whole Person Care

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication

CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing
UM-016 Transportation Guidelines

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health: ECM Program
ECM Provider ECM Assessment

Staff Person Completing Form:
Date Form Completed:

Demographics

Name:_____

DOB: _____ AAH#:_____ CIN:_____

Type of Assessment: ☐ New ☐ Annual

Race/Ethnicity: ☐ African American/Black ☐ Latino/Hispanic
☐ Asian/Pacific Islander ☐ Native American
☐ Black/Non-Hispanic ☐ White/Non-Hispanic
☐ More than one race/ethnicity
☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Transgender (F->M M->F) ____ ☐ Non-binary ☐ Other _____

Any cultural/religious preferences related to member's healthcare? ☐ Yes ☐ No

Preferred language:_____

*Is anything going on with your health right now that is causing you a lot of stress?
☐ Yes ☐ No

Describe:

How would you describe your overall health?
☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

Physical Environment

***Type of Residence:**
☐ Apartment
☐ House
☐ Assisted Living
☐ SRO (Permanent? Supported?)
☐ SNF
☐ Literally Homeless: If yes, please circle one of the following: car shelter encampment outside solo
☐ Temporary housing - alone
☐ Temporary housing-with friends and/or family
☐ Other:_____

If homeless, when was the last time you were stably housed?
_____

***Transportation:**
Do you have access to transportation?
☐ Yes ☐ No

If no, please describe your ability to access transportation:

***Safety:**
Do you feel safe in your home?
☐ Yes ☐ No

If no, what if anything would help right now?

Current Housing Programs:
☐ Section 8
☐ Housing Authority
☐ None
☐ Unknown
☐ Other: _____

Living Arrangement:
☐ Lives alone
☐ Lives with family/friends
☐ Lives with pet (indicate if certified service animal.

Financial Resources (optional):
Household Income per month (includes income of client and other household members)

Client Income Source:

Employment? Yes ☐ No ☐ Amount ___

SSD Yes ☐ No ☐ Amount ___

SSI Yes ☐ No ☐ Amount ___

Food Stamps Yes ☐ No ☐ Amount ___

TANF Yes ☐ No ☐ Amount ___

Unemployment Yes ☐ No ☐ Amount ___

VA Benefits Yes ☐ No ☐ Amount ___

Gen. Assistance Yes ☐ No ☐ Amount ___

Other Yes ☐ No ☐ Amount ___

Total _____

No Resources (circle if applicable)

Clinical Information

Physical Health Diagnoses (focus on chronic conditions):
_____

Mental Health Diagnoses: _____

Primary Care Physician: _____
Phone Number: _____
Specialty Physician(s): _____
Phone Number: _____
Name of pharmacy/service and contact number (if applicable): _____

Medical Facility most often used (ED/Hospital): _____

*How well do you understand your diagnoses and/or prescriptions? ☐ Not well ☐ Well enough ☐ Very well

*Do you have trouble getting appointments with your primary health care provider? ☐ Yes ☐ No

When was your last visit to Primary Care Provider? _____

When is your next visit to Primary Care Provider? _____

*Do you receive dental care? ☐ Yes ☐ No
If yes name of dentist: _____ Phone number: _____

*Do you have pain when eating? ☐ Yes ☐ No

	Yes	**No**	**Details**
In last 12 months, have you been to the ER or been hospitalized?	☐	☐	
Have you ever been hospitalized for mental health?	☐	☐	
Have you followed up with doctor since hospitalization?	☐	☐	
	Yes	**No**	**Details**
In last 12 months, have you had any surgeries?	☐	☐	
Have you followed up with doctor since surgery?	☐	☐	

Medications

Do you have any prescription or over-the-counter medications? ☐ Yes ☐ No

Name of medication:	Dose (ex. 5 mg)	Route (by mouth, subcutaneous)	Frequency (daily, weekly, as needed, etc)	Diagnosis	Date filled / expired

*Is there anything that makes it hard to take your medications as prescribed?
Some options below for you and patient to check off. "Do you ever…"

☐ Forget to take medications ☐ Forget to refill prescriptions on time ☐ Doubt the value of your medications ☐ Have problems reading the labels, because they're in the wrong language ☐ Have trouble reading the labels because you can't see well ☐ Have medication side effects	☐ Have difficulty opening pill bottles ☐ Get concerned about drug safety ☐ Get confused about medicines ☐ Have trouble getting to the pharmacy to pick up your medicines ☐ Have trouble affording your medicines ☐ Other: _____

Do you take any herbal remedies? ☐ Yes ☐ No

List any here:

Allergies		**Description**
Seasonal/ Environmental allergies	☐	
Allergies to medications	☐	
Food allergies	☐	

Pain

*Do you have chronic pain? ☐ Yes ☐ No

Details (Include things like location, cause, triggers):

What is the impact of the pain on your daily functioning? ("can you get through your day without interruption or does the pain keep you from doing certain things?")

	0= no pain	1= mild pain	2= moderate pain	3= severe pain	4= very severe pain	5= worst Possible pain
On a pain scale of 0-5 what number would you give your pain right now?	☐	☐	☐	☐	☐	☐
What number would you give your pain	☐	☐	☐	☐	☐	☐

when it is the worst that it gets?						
What number would you give your pain when it is the best that it gets?	☐	☐	☐	☐	☐	☐
At what number is the pain at an acceptable level for you?	☐	☐	☐	☐	☐	☐

Do you take medication for pain? ☐ Yes (which medicines) ☐ No	Does medication relieve the pain? ☐ All of the time ☐ Some of the time ☐ None of the time

Food Security:

*Do you have trouble accessing food?
☐ Yes☐ No

How many meals do you eat each day?
☐ 0-1☐ 2-3☐ 4-5☐ 6+

In the past 12 months have you worried that your food would run out before getting money to buy more?
☐ Yes ☐ No

In the past 12 months has your food run out because you didn't have money to get more?
☐ Yes ☐ No

Functional Assessment:

Hearing/Vision Deficits	**Yes**	**No**	
*Do you have trouble hearing?	☐	☐	Do you have hearing aids? ☐ Yes ☐ No
*Do you have trouble seeing?	☐	☐	Do you wear glasses or contacts? ☐ Yes ☐ No How is your eyesight with glasses/contacts? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

Communication Barriers	**Yes**	**No**	**Notes**
Do you speak English comfortably	☐	☐	
Do you feel your speech is impaired	☐	☐	
Do you feel you have memory loss	☐	☐	
Do you feel you have trouble thinking clearly	☐	☐	

How often do you have someone help you read health care materials? ☐ Always ☐ Sometimes ☐ Never
How confident are you at filling out medical forms by yourself? ☐ Always ☐ Sometimes ☐ Never

Physical Functioning

Stairs:	**Fall Risk**
Any stairs at home? ☐ Yes ☐ No Your ability to climb one flight of stairs: ☐ No difficulty ☐ Difficulty ☐ Unable ☐ N/A – no stairs	*Have you fallen within the last 6 months? ☐ Yes ☐ No If yes, how many times?_____ Do you have fear of falling ☐ Yes ☐ No

☐ N/A – uses ramp, wheelchair, etc	Details:

Level of help needed:						
***ADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Bathing	☐	☐	☐	☐		☐
Toileting	☐	☐	☐	☐		☐
Dressing	☐	☐	☐	☐		☐
Walking	☐	☐	☐	☐		☐
Feeding	☐	☐	☐	☐		☐

Any home modifications needed?
☐ Yes ☐ No
Describe modifications needed:

Level of help needed:						
***IADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Taking Medications	☐	☐	☐	☐		☐
Hygiene (brushing teeth, brushing hair, shaving)	☐	☐	☐	☐		☐
Housekeeping/Chores	☐	☐	☐	☐		☐
Shopping/Errands	☐	☐	☐	☐		☐
Meal Preparation or Cooking	☐	☐	☐	☐		☐
Accessing Resources	☐	☐	☐	☐		☐
Managing Money	☐	☐	☐	☐		☐
Transportation	☐	☐	☐	☐		☐
Keeping track of appointments	☐	☐	☐	☐		☐
Going out to visit family or friends	☐	☐	☐	☐		☐
Using the phone	☐	☐	☐	☐		☐

*Can you live safely and move easily around in your home? ☐ Yes ☐ No

If No, does the place where you live have:

Good lighting ☐ Yes ☐ No
Good heating ☐ Yes ☐ No
Good cooling ☐ Yes ☐ No
Rails for any stairs or ramps ☐ Yes ☐ No
Hot water ☐ Yes ☐ No
Indoor toilet ☐ Yes ☐ No
A door to the outside that locks ☐ Yes ☐ No
Stairs to get into your home or stairs inside your home ☐ Yes ☐ No
Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No
Clear ways to exit your home ☐ Yes ☐ No

*Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No Who helps you with ADLs/IADLs? ☐ Caregiver/IHSS ☐ Family ☐ Other ☐ No one *Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No	*Do you always have transportation available to get medical care? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Assistive Devices:

Do you use any assistive devices such as a Cane, Walker, Tub/Shower Chair, Ramp, Commode, Raised Toilet Seat, Hospital Bed, Safety Rail, Respiratory Aids, Oxygen, or other? ☐ Yes ☐ No

Details:

*Do you have any problems or concerns with devices used? ☐ Yes ☐ No
Details:

*Do you need any additional assistive devices? ☐ Yes ☐ No
Details:

Home and Community Based Services

***IHSS (In-Home Support Services):** Receives IHSS: ☐ Yes ☐ No

Hours per month: _____ Services provided by IHSS:

☐ Name of IHSS Worker:_____

Is that worker (insert name) a:

☐ Independent Provider

☐ Family Member

☐ Other:_____

CBAS (Community-Based Adult Services):

Do you attend CBAS? ☐ Yes ☐ No

Days per week: _____

If yes, name of CBAS Center you attend:

_____

Other Home & Community Based Services:

Other services received? ☐ Yes ☐ No

List specific organizations used and services received below:

(Examples-home health, meals on wheels)

Substance Use and Behavioral Health:

Substance Use:

I have some questions about your experience with alcohol, cigarettes, marijuana, and other drugs. Some of the substances we'll talk about are prescribed by a doctor, but I will only be focusing on whether you've taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	Once or Twice	Monthly	Weekly	Daily	Date of last use	Is this substance a problem for you?
Alcohol • For men, 5 or more drinks • For women, 4 or more drinks							Yes ☐ No ☐
Cigarettes							Yes ☐ No ☐
Prescription Drugs for Non-Medical Reasons (circle any relevant) • Pain medicines • ADHD medicines (ex Ritalin) • Sleeping pills							Yes ☐ No ☐
Marijuana							Yes ☐ No ☐

Other drugs Cocaine, Meth, Heroin, Hallucinogens (Acid, Mushrooms, PCP, Ecstasy)							Yes ☐ No ☐

***If the client answers that he/she uses any of the above substances, and especially if he/she identifies use as a problem, ask:**
Are you willing to receive a referral to a substance use counselor? ☐ Yes ☐ No

Mental Health:

Are you receiving any psychological counseling or treatment? ☐ Yes ☐ No
Name of provider:_____
How long have you been in treatment? _____
How's it going?

_____

_____

*Are there any life crises affecting you now? ☐ Yes ☐ No
Please describe:

*Would you like to talk to someone about your feelings? ☐ Yes ☐ No
Are you interested in counseling/therapy/support group? ☐ Yes ☐ No

Have you ever received mental health or counseling services in the past? ☐ Yes ☐ No
If yes, name of provider:
Have you ever had a doctor tell you that you had a mental health condition? ☐ Yes ☐ No
If yes, what was that condition?

_____

*Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

Mood/Depression/Suicide

Over the last 2 weeks:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐
How often have you been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
→STOP: * If the answers to one or both of the above questions are ***"More than half the days" or "Nearly every day"*** then complete the next seven questions. Otherwise, skip to the next section, "Social Resources."				
How often have you had trouble falling asleep, or sleeping too much?	☐	☐	☐	☐
How often have you been bothered by feeling tired or having little energy?	☐	☐	☐	☐

How often have you had a poor appetite or overeaten?	☐	☐	☐	☐
How often have you felt bad about yourself, or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
How often have you had trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
How often have you moved or spoken so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
How often have you had thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Cognitive Function/Dementia (document patient's response)

1. What year is it? _____
2. What month is it? _____
3. Give the patient an address phrase to remember with 5 components – example: John, Smith, 42 High Street, Oakland
4. About what time is it (within one hour)? _____
5. Count backwards from 20-1. _____
6. Say the months of the year in reverse _____
7. Repeat address phrase _____

Social Resources

How often do you see or speak with family or friends?
☐ Daily ☐ Several times per week ☐ Several times per month ☐ Less than once per month ☐ Never
*Over the past month (30 days), how many days have you felt lonely?
☐Most days (I always feel lonely) ☐ More than half the days (more than 15)☐ l Less than 5 days☐ None I(I never feel lonely)

Do you participate in any social, faith-based or other community activities? ☐ Yes ☐ No
If so, please name here:

Abuse/Neglect

	Yes	No	Details
*Are you ever afraid of or intimidated by someone in your family or household?	☐	☐	
*Has someone in your family or household ever been verbally abusive or tried to control what you can or cannot do?	☐	☐	
* Are you afraid of anyone or is anyone hurting you (including someone in your household or in your family?	☐	☐	

*Is anyone using your money without your ok?	☐	☐	

Advanced Planning: I'd like to talk with you about something called advance care planning. Have you given thought to the type of medical care you would want to have or not have if you ever became too ill or injured to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even in times when you are unable to speak for yourself. Did you know you could document your preferences ahead of time so that your care team knows about them? Would you like to talk more about how to do that?

☐ Yes☐ No

**If patient answers yes, please create a goal for the PCP or nurse/social worker on your team to talk with the patient about Advanced Directive, DPOA, and/or POLST.*

Does anyone help you make healthcare decisions or participate in your care plan?

☐ Yes☐ No

If yes, who:_____

General Health Questions
*What could you do right now to improve your health?

*What are your top 3 goals and priorities for the next 12 months?
Have you taken any steps to get to these yet?
Any asterisked (*) question on this assessment with a concerning response should be addressed in the HAP. Can be addressed either directly through goal setting, or alternatively through prompts to remind your team to follow up on the issues at a future time.

Clients Name:	Male☐ Female ☐ Other ☐	Date of Birth:
ECM Provider:	Care Coordinators Name:	Care Coordinators Phone:
PCP:	Enrollment Date:	Graduation Date:
Summary: ECM Provider long term goal for client:		
Initial HAP Screenings (if applicable)		
Screen:	Date	Score / Level
Katz ADL		
PHQ-9		
Audit - C		

SMART - **S**pecific **M**easurable **A**chievable **R**elevant **T**ime
Client's Long Term Goal(s):

Initial :		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Three Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Six Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Nine Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:

Attachment A – Alameda Alliance ECM Graduation Bundle

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)
42 CFR § 441.301 - Contents of request for a waiver. | CFR | US Law | LII / Legal Information Institute (cornell.edu)
APL17-013.pdf (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-011
Policy Name	Enhanced Care Management – Care Management & Transitions of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	02/01/2000
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	~~10/19/2023~~TBD

POLICY STATEMENT

Outreach and engagement are ensured and Enhanced Care Management (ECM) services are prioritized according to risk grouping tiers by ECM Providers. ECM Members are thoroughly assessed, including complex medical conditions, behavioral conditions and/or social needs. Health Action Plans (HAPs) are developed to assist in the management of the Member's needs including housing (instability, homelessness), Transition of Care support and Referral tracking and follow-up. Improving Quality of Care, patient safety and prevention of unnecessary hospital or emergency department admissions/visits are a key focus.

PROCEDURE

1.0 Pre-enrollment Member Outreach and Engagement

1.1 Each ECM Provider is responsible for developing and implementing outreach and engagement strategies for the purpose of enrolling Members into ECM. Outreach and engagement efforts are made according to Members' tiering level, where High Tier Members have priority, followed by Low Tier Members.

1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible to develop and implement an outreach and engagement plan for each eligible ECM Member. Lead Care Managers who serve adults living in the community who are risk of Long Term Care (LTC) institutionalization

and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (Per 42 CFR § 438.208 the care plan must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)) for members with long-term services and supports (LTSS) needs. If the ECM Member contacts the ECM Provider or AAH to requests a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager. This process is the same for subcontracted plans (delegates).

1.2.1 Care team assignments for conducting outreach and enrollment should be customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location and other characteristics, as appropriate.

1.2.2 Individuals assigned to conduct outreach and engagement for enrollment and ongoing engagement may include, but are not limited to, community health workers and care coordinators.

1.2.3 Engagement plans are individualized using various approved strategies most appropriate for each Member, including provisions for Members experiencing homelessness.

1.2.4 Outreach and engagement plans take into account any background information available from care records, claims, or other providers regarding physical and behavioral health conditions, history of trauma, Member's language and cultural preferences, health literacy, preferred modes of communication (e.g., phone versus text), housing and work history, current housing status other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when/where/how the Member has sought care in the past.

1.2.5 Active outreach strategies may include but not be limited to:

1.2.5.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

1.2.5.2 With member permission, direct communications with Members by letter, email, texts, telephone;

1.2.5.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

1.2.5.4 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

1.2.6 Outeach efforts for high priority members will progress over ninety (90) days from the ECM Provider's receipt of the attributed ECM Member list. Outreach efforts will consist of:

1.2.6.1 Assigned Members in the High Tier will receive a minimum of every other week outreach contacts/attempts.

1.2.6.2 Assigned Members in the Low Tier will receive a minimum of monthly outreach contacts/attempts.

1.2.7 All attempts to contact will be documented within the ECM Provider's care management platform or equivalent platform.

1.2.7.1 During initial contact by an ECM Provider care team member conducting outreach, each Member is fully informed about ECM and terms of their participation, in accordance with this policy, and

asked to either consent or decline to participate in ECM. A successful outreach contact shall consist of the following:

1.2.7.1.1 Confirm Member eligibility for ECM.

1.2.7.1.2 Verify if Member is receiving any care management/coordination services with any other program.

1.2.7.1.2.1 If the Member self-reports in the negative, they can be enrolled in ECM.

1.2.7.1.2.2 If the Member confirms enrollment in another program, they will be advised to choose only one of the programs.

1.2.7.1.3 As Members are reassessed, the ECM Provider team will again verify that the Member is not enrolled in duplicate care management/care coordination services or programs.

1.2.7.2 Document the Member's verbal or written consent in the care management record.

1.2.7.3 Notify and coordinate care with the Member's PCP and relevant specialty providers of Member's enrollment in ECM.

1.2.7.4 Either initiate or plan to complete the HAP with Member.

1.2.7.5 If the Member declines to participate in ECM:

1.2.7.5.1 Member is informed regarding continuing care with their PCP and obtaining assistance with coordination, as appropriate.

1.2.7.5.2 Member is informed that they may re-engage and receive ECM services at any time in the future as long as he or she continues to meet ECM eligibility requirements.

1.2.7.5.3 Declination is documented in the ECM Provider's care management platform or system of record.

1.2.7.6 AAH monitors, documents, and reports the progress and results of all ECM activities required to be reported to the Department of Health Care Services (DHCS), in accordance with provisions of this policy and any DHCS Program Guide.

2.0 Health Action Plan

2.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP (See Related Workflow Documents or Other Attachments).

2.2 ECM Assessment

2.2.1 The ECM Assessment is administered to provide a deeper base of knowledge needed to address complex medical conditions, longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

2.2.1.1 Physical health;

2.2.1.2 Mental health;

2.2.1.3 Substance Use Disorder (SUD);

2.2.1.4 Community-based Services;

2.2.1.5 Palliative care;

2.2.1.6 Trauma-informed care needs;

2.2.1.7 Social Supports;
2.2.1.8 Housing and other Social Determinants of Health; and
2.2.1.9 Utilization

2.2.2 Addressing palliative care and trauma informed care needs

2.2.2.1 The ECM Assessment addresses the following palliative care domains: pain; difficulty taking medications; physical function; social connections; and advance (directive) planning. The Alliance incorporates the elements of palliative care into the ECM Assessment without using the word "palliative."

2.2.2.2 The ECM Assessment addresses the following trauma-informed care domains: safety, mental health, substance use disorder, pain, utilization, and disease burden. The Alliance incorporates the components of trauma-informed care into the ECM Assessment without using the word, "trauma" and uses open-ended questions designed to elicit responses that could include experiences considered to be traumatic.

2.2.2.3 Recognizing that palliative care and trauma-informed-care may be new skill sets for ECM Provider staff, trainings to address and improve palliative care and trauma-informed care assessments will be regularly offered to ECM Providers.

2.2.3 ECM Providers make multiple efforts to contact newly enrolled ECM Members to conduct the ECM Assessment which will be repeated yearly and with any transition in care or other major event.

2.2.4 Following Member consent to enroll, Members identified as higher risk will be prioritized for the outreach and engagement to conduct and complete the ECM Assessment.

2.2.5 For the High Tier priority engagement group, ongoing attempts to contact occurs weekly using multiple modalities such as phone, email, and text (per the Member's documented preference) and at varying times of day and evening, for up to ninety (90) days.

2.2.6 For the Low Tier group, ongoing attempts to contact occurs monthly using multiple modalities and times of day and evening, for up to ninety (90) days.

2.2.7 If unable to contact the Member by phone or mail, every avenue is researched to secure a valid phone number (e.g. the PCP office, specialty care provider office, a vendor where durable medical equipment is rented from, current pharmacy used, or data available on other data exchange platforms, etc.).

2.2.8 The ECM Provider will document all contact attempts in their care management platform or system of record.

2.2.9 To facilitate communication among the Member's health care Providers, the completed ECM Assessment is made available to the entire ECM Provider team and the Member's PCP.

2.2.10 AAH ECM Providers will track, trend, monitor, and report ECM Assessment administration and reassessment practices for all eligible members.

2.3 Care Plan

2.3.1 Once the ECM Assessment is completed, the designated ECM Provider team member develops the Care Plan for each Member enrolled in ECM

services in collaboration with the Member, caregiver, and other members of the ECM Provider team.

2.3.2 The designated ECM Provider team member works with the Member to develop and prioritize goals according to the Member's priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal. Members have the opportunity to be involved in the development, review, and approval of the Care Plan and any amendments to the Care Plan, as appropriate.

2.3.3 The Care Plan is developed using the ECM Assessment data as well as other information available from various sources such as utilization data, pharmacy data, or notes from any AAH Care Management (CM) activities.

2.3.4 The Care Plan will include, but is not limited to, the following elements, as appropriate:

- 2.3.4.1 Language and communication preferences;
- 2.3.4.2 Risk level or complexity tier;
- 2.3.4.3 Housing status;
- 2.3.4.4 Care team supports, including contact information;
- 2.3.4.5 Emergency Department (ED)/hospital utilization;
- 2.3.4.6 Medications and dosage;
- 2.3.4.7 Any care needs identified on the ECM Assessment pertaining to chronic physical condition, behavioral health status including cognitive functions, developmental health and dementia, trauma-informed care, palliative care needs, and specific goals and action plan;
- 2.3.4.8 Self-management goals, including barriers to success, interventions, and goal status;
- 2.3.4.9 Timeframes for reassessment and ECM Provider follow-up frequency;
- 2.3.4.10 Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);
- 2.3.4.11 Care coordination and social support needs such as arranging transportation, obtaining appointments, referral tracking and status updates (including housing referrals), coordinating interpreter services, and educating on the importance of preventative services.

2.3.5 The HAP is accessible to all members of the care team:

- 2.3.5.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.
- 2.3.5.2 The PCP will be given the Member's HAP.
- 2.3.5.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

2.3.6 Quarterly, or more frequently if needed, the ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status or health care needs and/or according to the HAP follow up plan. A clinician at the ECM Provider reviews the HAP. AAH clinician ensures that appropriate ECM clinician has provided oversight to ensure the HAP is maintained and updated as appropriate

through quarterly audits.

2.3.6.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission, discharge or ED visit. This will alert them to contact the Member, as appropriate, to review the current HAP and make changes as necessary.

2.3.6.2 The ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.

2.3.6.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met, or is no longer applicable.

2.3.6.4 The HAP will be completed within ninety (90) days of ECM enrollment.

3.0 Member Ongoing Engagement and Care Management Services

3.1 ECM Provider team members provide ongoing care management support in person and telephonically at a frequency determined by the Member's complexity (Tier level) and desired level of involvement in ECM.

3.2 The ECM Lead Care Manager serves as the primary point of contact and supports activities provided by ECM Providers which include, but are not limited to:

3.2.1 Assessing and managing Members using evidence-based clinical protocols and resources;

3.2.2 Ensuring completion of HAP within specified timeframe;

3.2.3 Documenting Member's choice of caregiver or family/support persons and assisting Members and chosen family/support persons with access to appropriate resources;

3.2.4 Assisting Members and chosen family/support persons with scheduling appointments;

3.2.5 Tracking and monitoring internal and external referrals;

3.2.6 Developing and communicating self-management plans with input from the Member and caregiver(s)/family, as well as helping the member to identify and build on successes and potential family and/or support networks;

3.2.7 Providing appropriate, timely, and actionable Member education to improve self-management skills;

3.2.8 Empowering Members to enhance self-management using Motivational Interviewing techniques;

3.2.9 Using problem-based, comprehensive case planning, with measurable, prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments;

3.2.10 Providing care management that is Member-centric and culturally aware;

3.2.11 Interacting with Members and family and / or support persons from a holistic perspective, promoting collaboration and coordination, through all levels of the health care continuum including physical and behavioral health programs, pharmaceutical management, and community-based programs;

3.2.12 Monitoring and supporting treatment adherence (including medication management and reconciliation);

3.2.13 Assisting in attainment of the Member's goals as described in the HAP;

3.2.14 Encouraging the Member's decision-making and continued participation in ECM; and

3.2.15 Accompanying Members to appointments, as needed.

3.3 AAH ensures that the ECM Member's acuity will be the basis for the appropriate provision of ECM services by the ECM Provider. Members in the higher acuity risk groupings (tiers) will receive more intensive ECM services at a higher frequency.

3.3.1 High Risk (High Tier)

3.3.1.1 Attempt weekly contacts with the Member and, at a minimum, one in-person meeting per month. The in-person meeting per month may be temporarily suspended during a declared public health emergency; however, alternative means of communication with the Member should be employed to contact the Member during this time including secure teleconferencing and telehealth visits;

3.3.1.2 On-going communication with PCP regarding HAP updates and information-sharing;

3.3.1.3 Weekly, systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member's HAP, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their Care Plan; and

3.3.1.4 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

3.3.2 Low/Medium Risk (Low Tier)

3.3.2.1 Attempt monthly contacts with the Member;

3.3.2.2 ECM Provider staff can utilize a combination of telephonic and face-to-face encounters, based on the Member's preference, and as documented in the HAP. In-person meeting may be temporarily suspended during a declared public health emergency; however, alternative means of communication with member should be employed to contact member during this time including secure teleconferencing and telehealth visits.

3.3.2.3 On-going communication with PCP regarding HAP updates and information sharing;

3.3.2.4 Periodic systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member HAP's, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their care plan; and

3.3.2.5 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

4.0 Housing

4.1 ECM Members in need of housing services may be identified as follows:

4.1.1 ECM Providers conduct an ECM Assessment upon enrollment, annually, and with any change in status. The ECM Assessment includes questions that identify Members' homelessness or housing instability concerns.

4.1.2 Care team may be alerted to Members' housing concerns through the regular course of providing comprehensive care management services.

4.2 Members experiencing homelessness or housing instability will include goals

related to housing on their HAP. Goals may address:

4.2.1 Housing navigation;
4.2.2 Transitional support;
4.2.3 Tenancy support;
4.2.4 Assistance in finding permanent housing.
4.2.4.1 Referrals to housing navigation is a component of the ECM Provider care coordinator's functions.

4.3 AAH will provide the following support to ECM Providers:
4.3.1 Cultivate relationships with local housing agencies including permanent housing providers;
4.3.2 Cultivate relationships with homeless service providers;
4.3.3 Provide advocacy for Members through housing agencies and coalitions; and
4.3.4 Partner with Alameda County Health Care Services Agency (HCSA) and Corporation for Supportive Housing to create and provide educational offerings and technical assistance around housing navigation and tenancy supports, as needed.

5.0 Referral Management

5.1 Referral management is a component of the ECM Provider care coordinator's primary responsibilities. The ECM Provider care coordinator will track, monitor and provide referral coordination for all new, pending or completed referrals captured within the web-based care management platform or equivalent platform.
5.1.1 The ECM Assessment is the opportunity to gather and document relevant information regarding a member's needs, including medical health, behavioral health, palliative care, and social needs.
5.1.2 A member-centered plan of care is generated from the ECM Assessment which includes referrals agreed to by the ECM Member. These referrals may link ECM Members to medical specialty care, primary care, behavioral health, long term care services, palliative care, housing, community supports and any community resources which address the Member's needs.
5.1.3 Referrals may be placed to various services and appropriate community agencies via fax, telephone, in person or through secure electronic methods.
5.1.4 ECM Providers ensure that referrals were received and processed by the receiving agencies or providers, track whether services were received by the ECM Member and document the outcomes of the referrals.
5.1.5 Referrals will be followed up by phone, fax, in person or via secure electronic pathways, at scheduled intervals, to ensure that a referral has been completed and the ECM Member appropriately linked to services.

5.2 Referral and transition coordination include the following activities:
5.2.1 Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to internal or external referrals;
5.2.2 Review details and expectations about the referral with the Member and/or caregivers;
5.2.3 Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs, as appropriate, to referral source(s);

5.2.4 Assist Members in problem-solving potential barriers (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);
5.2.5 Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;
5.2.6 Remind patients of scheduled appointments based on the Member's preference and as documented in the HAP;
5.2.7 Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within specified timeframe, have cancelations, missed appointments, or other reasons for an incomplete referral;
5.2.8 Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and
5.2.9 Ensure the Member's health record is up to date with information on specialist consults, hospital summaries, diagnostic results, ED visits and community organization information related to the health of the Member.

6.0 Transitions of Care
6.1 AAH collaborates with ECM Provider staff to coordinate care across all healthcare settings, providers, and services to assure continuity of care.
6.2 ECM Providers, in partnership with AAH, continuously work with all facilities to ensure that Members are receiving comprehensive quality care in the least restrictive setting.
6.3 AAH ensures that ECM Providers have access to daily hospital admission, discharge and ED visit information for ECMMembers.
6.4 Member engagement and Transition of Care (TOC) activities begin during ED visit or hospital admission, when possible.
6.4.1 Upon notification of an ED visit or inpatient hospital admission, the ECM Provider care coordinator begins transition activities for ECM Members. Activities include, but are not limited to:
6.4.1.1 Engaging with the Member during their ED visit or hospitalization, if possible;
6.4.1.2 Engaging with the Member within 48 hours of their ED visit or hospital discharge;
6.4.1.3 Reviewing discharge plan and medication changes;
6.4.1.4 Updating HAP;
6.4.1.5 Referral management and coordination support; and
6.4.1.6 Scheduling timely follow-up appointment(s) with the Member's PCP and specialists, as appropriate.
6.4.1.6.1 Includes arranging transportation for transition care and to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policies and procedures.
6.4.1.7 Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.
6.4.1.7.1 When possible, provide transition support to permanent housing.
6.4.1.8 The ECM Provider team contacts the Member to monitor their status before, during and after a transition of care, when possible.
6.4.2 The ECM Provider care coordinator will update the ECM Provider team, or

the multidisciplinary care team, who will assist with the coordination and delivery of services or schedule case conferences to discuss supportive measures needed, changes to the HAP, and discussions to prevent future utilization.

6.4.3 ECM Providers have ongoing communication with facilities to monitor Members' needs and the services provided to them.

6.4.3.1 AAH prevents readmissions by utilizing evidence-based best practices for Transitions of Care and encouraging ECM Providers to follow the same. AAH tracks readmissions via an ECM-specific dashboard that is shared with ECM Providers on a regular basis.

7.0 Member Transition to Lower Level of Care/Disenrollment

7.1 ECM Provider teams will continue to reassess the Member's risk status level and programmatic appropriateness.

7.1.1 Members transitioning to ECM from the Health Homes Program (HHP) or Whole Person Care (WPC) Pilot will be reassessed within a period of six (6) months to determine the most appropriate level of services for each Member, whether in ECM or a lower level of care coordination.

7.1.2 When Members have experienced a 6-month period of stability, defined by well managed clinical measures, no hospital or ED utilization and have successfully met their self-management goals on the HAP, they are ready to transition to a lower level of care and disenroll or "graduates" from ECM.

7.1.3 If a Member consented and engaged in ECM but has had no active participation for ninety (90) days, despite ongoing outreach and engagement efforts by the ECM Provider team, the Member will be disenrolled.

7.1.4 If a Member chooses to disenroll for any reason, the Member will be disenrolled.

7.1.5 If a Member is now participating in another program excluding them from ECM eligibility, the Member may choose the alternate program and be disenrolled from ECM.

7.1.6 The disenrollment reason will be documented in the web-based care management platform or equivalent platform.

7.1.7 The ECM provider will notify AAH when the member is ready to transition to a lower level of care. The ECM Provider will use the Alliance Enhanced Care Management Graduation Bundle (Attachment A) to determine when an ECM Member is ready for graduation and ready to transition to a lower level of care. AAH will not be determining the member's readiness for graduation but will follow the recommendation of the ECM Provider who is providing the direct services. AAH will follow the standard Grievance & Appeals process when a member disputes ECM graduation and transition to a lower level of care.

7.1.8 The provider will provide a warm handoff, when appropriate, to the receiving lower level Care Management provider. Lower level Care Management may include programs at the ECM Provider, or other community Care Management entities, including AAH telephonic Care Management. If the ECM Provider has difficulty locating an appropriate lower level of care provider, the Alliance will assist in identifying an appropriate provider, including acceptance of the member into the AAH

telephonic care management program. AAH will work with ECM Provider to graduate the member and transition to a lower level of care when needed.

7.2 The process ECM Providers are expected to use to notify the Alliance when discontinuation criteria are met is through the monthly submission of the DHCS Member Information File. This file includes Disenrollment Reason codes notifying the Plan of discontinuation of delivery (e.g. graduation, disenrollment, unwilling to engage, provider unable to connect after multiple attempts).Upon notification from the ECM Provider, AAH will issue a Notice of Action (NOA) to Members disenrolled from ECM for specific situations. AAH will send the NOA to the Member, ECM provider and PCP within thirty (30) days after the effective date of ECM disenrollment. AAH will send a NOA to the Member, the ECM Provider, and the Member's PCP (if the ECM Provider is not the Member's PCP) if:

- 7.2.1 The Member develops a change in eligibility such as an exclusionary condition;
- 7.2.2 The Member's eligible chronic condition(s) become well-managed (for six consecutive months);
- 7.2.3 The Member has met all care plan goals;
- 7.2.4 The Member is ready to transition to a lower level of care;
- 7.2.5 The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
- 7.2.6 A Member consents and enrolls, but there is no documented active participation for ninety (90) days despite outreach and engagement efforts as part of care management.
- 7.2.7 When ECM services are discontinued; the Member or the ECM Provider may request the member be transitioned to a lower level of care management. AAH will work with the ECM Provider to complete a warm handoff to AAH's telephonic Case Management or to a community-based case management program.

7.3 AAH will not send a NOA to a member who chooses to disenroll from ECM.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
NOA	Notice of Action
ECM	Enhanced Care Management
HAP	Health Action Plan
TOC	Transition of Care
WPC	Whole Person Care

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication

CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing
UM-016 Transportation Guidelines

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health: ECM Program
ECM Provider ECM Assessment

Staff Person Completing Form:
Date Form Completed:

Demographics

Name:_____

DOB: _____ AAH#:_____ CIN:_____

Type of Assessment: ☐ New ☐ Annual

Race/Ethnicity: ☐ African American/Black ☐ Latino/Hispanic
☐ Asian/Pacific Islander ☐ Native American
☐ Black/Non-Hispanic ☐ White/Non-Hispanic
☐ More than one race/ethnicity
☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Transgender (F->M M->F) ____ ☐ Non-binary ☐ Other _____

Any cultural/religious preferences related to member's healthcare? ☐ Yes ☐ No

Preferred language:_____

*Is anything going on with your health right now that is causing you a lot of stress?
☐ Yes ☐ No

Describe:

How would you describe your overall health?
☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

Physical Environment

***Type of Residence:**
☐ Apartment
☐ House
☐ Assisted Living
☐ SRO (Permanent? Supported?)
☐ SNF
☐ Literally Homeless: If yes, please circle one of the following: car shelter encampment outside solo
☐ Temporary housing - alone
☐ Temporary housing-with friends and/or family
☐ Other:_____

If homeless, when was the last time you were stably housed?
_____

***Transportation:**
Do you have access to transportation?
☐ Yes ☐ No

If no, please describe your ability to access transportation:

***Safety:**
Do you feel safe in your home?
☐ Yes ☐ No

If no, what if anything would help right now?

Current Housing Programs:
☐ Section 8
☐ Housing Authority
☐ None
☐ Unknown
☐ Other: _____

Living Arrangement:
☐ Lives alone
☐ Lives with family/friends
☐ Lives with pet (indicate if certified service animal.

Financial Resources (optional):
Household Income per month (includes income of client and other household members)

Client Income Source:

Employment? Yes ☐ No ☐ Amount ___

SSD Yes ☐ No ☐ Amount ___

SSI Yes ☐ No ☐ Amount ___

Food Stamps Yes ☐ No ☐ Amount ___

TANF Yes ☐ No ☐ Amount ___

Unemployment Yes ☐ No ☐ Amount ___

VA Benefits Yes ☐ No ☐ Amount ___

Gen. Assistance Yes ☐ No ☐ Amount ___

Other Yes ☐ No ☐ Amount ___

Total _____

No Resources (circle if applicable)

Clinical Information

Physical Health Diagnoses (focus on chronic conditions):
_____

Mental Health Diagnoses: _____

Primary Care Physician: _____
Phone Number: _____
Specialty Physician(s): _____
Phone Number: _____
Name of pharmacy/service and contact number (if applicable): _____

Medical Facility most often used (ED/Hospital): _____

*How well do you understand your diagnoses and/or prescriptions? ☐ Not well ☐ Well enough ☐ Very well

*Do you have trouble getting appointments with your primary health care provider? ☐ Yes ☐ No

When was your last visit to Primary Care Provider? _____

When is your next visit to Primary Care Provider? _____

*Do you receive dental care? ☐ Yes ☐ No
If yes name of dentist: _____ Phone number: _____

*Do you have pain when eating? ☐ Yes ☐ No

	Yes	**No**	**Details**
In last 12 months, have you been to the ER or been hospitalized?	☐	☐	
Have you ever been hospitalized for mental health?	☐	☐	
Have you followed up with doctor since hospitalization?	☐	☐	
	Yes	**No**	**Details**
In last 12 months, have you had any surgeries?	☐	☐	
Have you followed up with doctor since surgery?	☐	☐	

Medications

Do you have any prescription or over-the-counter medications? ☐ Yes ☐ No

Name of medication:	Dose (ex. 5 mg)	Route (by mouth, subcutaneous)	Frequency (daily, weekly, as needed, etc)	Diagnosis	Date filled / expired

*Is there anything that makes it hard to take your medications as prescribed?
Some options below for you and patient to check off. "Do you ever…"

☐ Forget to take medications ☐ Forget to refill prescriptions on time ☐ Doubt the value of your medications ☐ Have problems reading the labels, because they're in the wrong language ☐ Have trouble reading the labels because you can't see well ☐ Have medication side effects	☐ Have difficulty opening pill bottles ☐ Get concerned about drug safety ☐ Get confused about medicines ☐ Have trouble getting to the pharmacy to pick up your medicines ☐ Have trouble affording your medicines ☐ Other: _____

Do you take any herbal remedies? ☐ Yes ☐ No

List any here:

Allergies		**Description**
Seasonal/ Environmental allergies	☐	
Allergies to medications	☐	
Food allergies	☐	

Pain

*Do you have chronic pain? ☐ Yes ☐ No

Details (Include things like location, cause, triggers):

What is the impact of the pain on your daily functioning? ("can you get through your day without interruption or does the pain keep you from doing certain things?")

	0= no pain	1= mild pain	2= moderate pain	3= severe pain	4= very severe pain	5= worst Possible pain
On a pain scale of 0-5 what number would you give your pain right now?	☐	☐	☐	☐	☐	☐
What number would you give your pain	☐	☐	☐	☐	☐	☐

when it is the worst that it gets?						
What number would you give your pain when it is the best that it gets?	☐	☐	☐	☐	☐	☐
At what number is the pain at an acceptable level for you?	☐	☐	☐	☐	☐	☐

Do you take medication for pain? ☐ Yes (which medicines) ☐ No	Does medication relieve the pain? ☐ All of the time ☐ Some of the time ☐ None of the time

Food Security:

*Do you have trouble accessing food?
☐ Yes☐ No

How many meals do you eat each day?
☐ 0-1☐ 2-3☐ 4-5☐ 6+

In the past 12 months have you worried that your food would run out before getting money to buy more?
☐ Yes ☐ No

In the past 12 months has your food run out because you didn't have money to get more?
☐ Yes ☐ No

Functional Assessment:

Hearing/Vision Deficits	**Yes**	**No**	
*Do you have trouble hearing?	☐	☐	Do you have hearing aids? ☐ Yes ☐ No
*Do you have trouble seeing?	☐	☐	Do you wear glasses or contacts? ☐ Yes ☐ No How is your eyesight with glasses/contacts? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

Communication Barriers	**Yes**	**No**	**Notes**
Do you speak English comfortably	☐	☐	
Do you feel your speech is impaired	☐	☐	
Do you feel you have memory loss	☐	☐	
Do you feel you have trouble thinking clearly	☐	☐	

How often do you have someone help you read health care materials? ☐ Always ☐ Sometimes ☐ Never
How confident are you at filling out medical forms by yourself? ☐ Always ☐ Sometimes ☐ Never

Physical Functioning

Stairs:	**Fall Risk**
Any stairs at home? ☐ Yes ☐ No Your ability to climb one flight of stairs: ☐ No difficulty ☐ Difficulty ☐ Unable ☐ N/A – no stairs	*Have you fallen within the last 6 months? ☐ Yes ☐ No If yes, how many times?_____ Do you have fear of falling ☐ Yes ☐ No

☐ N/A – uses ramp, wheelchair, etc	Details:

Level of help needed:						
***ADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Bathing	☐	☐	☐	☐		☐
Toileting	☐	☐	☐	☐		☐
Dressing	☐	☐	☐	☐		☐
Walking	☐	☐	☐	☐		☐
Feeding	☐	☐	☐	☐		☐

Any home modifications needed?
☐ Yes ☐ No
Describe modifications needed:

Level of help needed:						
***IADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Taking Medications	☐	☐	☐	☐		☐
Hygiene (brushing teeth, brushing hair, shaving)	☐	☐	☐	☐		☐
Housekeeping/Chores	☐	☐	☐	☐		☐
Shopping/Errands	☐	☐	☐	☐		☐
Meal Preparation or Cooking	☐	☐	☐	☐		☐
Accessing Resources	☐	☐	☐	☐		☐
Managing Money	☐	☐	☐	☐		☐
Transportation	☐	☐	☐	☐		☐
Keeping track of appointments	☐	☐	☐	☐		☐
Going out to visit family or friends	☐	☐	☐	☐		☐
Using the phone	☐	☐	☐	☐		☐

*Can you live safely and move easily around in your home? ☐ Yes ☐ No

If No, does the place where you live have:

Good lighting ☐ Yes ☐ No
Good heating ☐ Yes ☐ No
Good cooling ☐ Yes ☐ No
Rails for any stairs or ramps ☐ Yes ☐ No
Hot water ☐ Yes ☐ No
Indoor toilet ☐ Yes ☐ No
A door to the outside that locks ☐ Yes ☐ No
Stairs to get into your home or stairs inside your home ☐ Yes ☐ No
Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No
Clear ways to exit your home ☐ Yes ☐ No

*Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No Who helps you with ADLs/IADLs? ☐ Caregiver/IHSS ☐ Family ☐ Other ☐ No one *Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No	*Do you always have transportation available to get medical care? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Assistive Devices:

Do you use any assistive devices such as a Cane, Walker, Tub/Shower Chair, Ramp, Commode, Raised Toilet Seat, Hospital Bed, Safety Rail, Respiratory Aids, Oxygen, or other? ☐ Yes ☐ No

Details:

*Do you have any problems or concerns with devices used? ☐ Yes ☐ No
Details:

*Do you need any additional assistive devices? ☐ Yes ☐ No
Details:

Home and Community Based Services

***IHSS (In-Home Support Services):** Receives IHSS: ☐ Yes ☐ No

Hours per month: _____ Services provided by IHSS:

☐ Name of IHSS Worker:_____

Is that worker (insert name) a:

☐ Independent Provider

☐ Family Member

☐ Other:_____

CBAS (Community-Based Adult Services):

Do you attend CBAS? ☐ Yes ☐ No

Days per week: _____

If yes, name of CBAS Center you attend:

_____

Other Home & Community Based Services:

Other services received? ☐ Yes ☐ No

List specific organizations used and services received below:

(Examples-home health, meals on wheels)

Substance Use and Behavioral Health:

Substance Use:

I have some questions about your experience with alcohol, cigarettes, marijuana, and other drugs. Some of the substances we'll talk about are prescribed by a doctor, but I will only be focusing on whether you've taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	Once or Twice	Monthly	Weekly	Daily	Date of last use	Is this substance a problem for you?
Alcohol • For men, 5 or more drinks • For women, 4 or more drinks							Yes ☐ No ☐
Cigarettes							Yes ☐ No ☐
Prescription Drugs for Non-Medical Reasons (circle any relevant) • Pain medicines • ADHD medicines (ex Ritalin) • Sleeping pills							Yes ☐ No ☐
Marijuana							Yes ☐ No ☐

Other drugs Cocaine, Meth, Heroin, Hallucinogens (Acid, Mushrooms, PCP, Ecstasy)							Yes ☐ No ☐

***If the client answers that he/she uses any of the above substances, and especially if he/she identifies use as a problem, ask:**
Are you willing to receive a referral to a substance use counselor? ☐ Yes ☐ No

Mental Health:

Are you receiving any psychological counseling or treatment? ☐ Yes ☐ No
Name of provider:_____
How long have you been in treatment? _____
How's it going?

_____

_____

*Are there any life crises affecting you now? ☐ Yes ☐ No
Please describe:

*Would you like to talk to someone about your feelings? ☐ Yes ☐ No
Are you interested in counseling/therapy/support group? ☐ Yes ☐ No

Have you ever received mental health or counseling services in the past? ☐ Yes ☐ No
If yes, name of provider:
Have you ever had a doctor tell you that you had a mental health condition? ☐ Yes ☐ No
If yes, what was that condition?

_____

*Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

Mood/Depression/Suicide

Over the last 2 weeks:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐
How often have you been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
→STOP: * If the answers to one or both of the above questions are ***"More than half the days" or "Nearly every day"*** then complete the next seven questions. Otherwise, skip to the next section, "Social Resources."				
How often have you had trouble falling asleep, or sleeping too much?	☐	☐	☐	☐
How often have you been bothered by feeling tired or having little energy?	☐	☐	☐	☐

How often have you had a poor appetite or overeaten?	☐	☐	☐	☐
How often have you felt bad about yourself, or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
How often have you had trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
How often have you moved or spoken so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
How often have you had thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Cognitive Function/Dementia (document patient's response)

1. What year is it? _____
2. What month is it? _____
3. Give the patient an address phrase to remember with 5 components – example: John, Smith, 42 High Street, Oakland
4. About what time is it (within one hour)? _____
5. Count backwards from 20-1. _____
6. Say the months of the year in reverse _____
7. Repeat address phrase _____

Social Resources

How often do you see or speak with family or friends?
☐ Daily ☐ Several times per week ☐ Several times per month ☐ Less than once per month ☐ Never
*Over the past month (30 days), how many days have you felt lonely?
☐Most days (I always feel lonely) ☐ More than half the days (more than 15)☐ l Less than 5 days☐ None I(I never feel lonely)

Do you participate in any social, faith-based or other community activities? ☐ Yes ☐ No
If so, please name here:

Abuse/Neglect

	Yes	No	Details
*Are you ever afraid of or intimidated by someone in your family or household?	☐	☐	
*Has someone in your family or household ever been verbally abusive or tried to control what you can or cannot do?	☐	☐	
* Are you afraid of anyone or is anyone hurting you (including someone in your household or in your family?	☐	☐	

*Is anyone using your money without your ok?	☐	☐	

Advanced Planning: I'd like to talk with you about something called advance care planning. Have you given thought to the type of medical care you would want to have or not have if you ever became too ill or injured to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even in times when you are unable to speak for yourself. Did you know you could document your preferences ahead of time so that your care team knows about them? Would you like to talk more about how to do that?

☐ Yes☐ No

**If patient answers yes, please create a goal for the PCP or nurse/social worker on your team to talk with the patient about Advanced Directive, DPOA, and/or POLST.*

Does anyone help you make healthcare decisions or participate in your care plan?

☐ Yes☐ No

If yes, who:_____

General Health Questions
*What could you do right now to improve your health?

*What are your top 3 goals and priorities for the next 12 months?
Have you taken any steps to get to these yet?
Any asterisked (*) question on this assessment with a concerning response should be addressed in the HAP. Can be addressed either directly through goal setting, or alternatively through prompts to remind your team to follow up on the issues at a future time.

Clients Name:	Male☐ Female ☐ Other ☐	Date of Birth:
ECM Provider:	Care Coordinators Name:	Care Coordinators Phone:
PCP:	Enrollment Date:	Graduation Date:
Summary: ECM Provider long term goal for client:		
Initial HAP Screenings (if applicable)		
Screen:	Date	Score / Level
Katz ADL		
PHQ-9		
Audit - C		

SMART - **S**pecific **M**easurable **A**chievable **R**elevant **T**ime
Client's Long Term Goal(s):

Initial :		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Three Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Six Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Nine Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:

Attachment A – Alameda Alliance ECM Graduation Bundle

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)
42 CFR § 441.301 - Contents of request for a waiver. | CFR | US Law | LII / Legal Information Institute (cornell.edu)
APL17-013.pdf (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

Orking on

POLICY AND PROCEDURE

Policy Number	CM-013
Policy Name	Enhanced Care Management – Oversight, Monitoring, & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	07/16/2020
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

In order to provide Enhanced Care Management (ECM) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of ECM Providers. AAH ensures that ECM Providers comply with program requirements as outlined in the DHCS-MCP ECM and ILOS Contract and ECM and ILOS Standard Provider Terms and Conditions.

PROCEDURE

1.0 Auditing and Oversight of ECM Provider Activities

1.1 AAH will conduct auditing and oversight of ECM Provider activities through the following:

1.1.1 Monthly monitoring of ECM referrals, enrollment, and reports

1.1.2 Quarterly monitoring of AAH internal reports

1.1.3 Annual ECM Provider onsite visits and case file review

2.0 Monthly Monitoring of ECM Enrollment Data and Reports

2.1 AAH receives ECM enrollment data and reports from ECM Providers.

2.1.1 ECM Provider reports are submitted monthly and are uploaded directly into the AAH SFTP site.

2.2 AAH Analytics team reviews the eligibility and enrollment reports and provides feedback or requests additional information from ECM Providers:

2.2.1 AAH Analytics team reviews data monthly. AAH Analytics team has 30 days upon receipt of report to review submission for content including, but not limited to, use of the correct report template, reporting period and content.

2.2.1.1 If report does not appear to reflect ECM activities, AAH Analytics team follows-up with the contracted ECM Provider to request clarification. AAH Analytics team will work with AAH ECM team and ECM Provider to identify solutions and close gaps.

2.2.1.2 If upon requested clarification additional concerns exist, a Corrective Action Plan (CAP) may be required.

2.2.1.3 If a CAP is requested and the ECM Provider does not meet or is unable to meet CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that ECM Provider is meeting ECM program delivery requirements.

3.0 Quarterly Monitoring of AAH Internal Reports

3.1 AAH collects and tracks operational and clinical data from ECM Providers, as well as internal data in order to manage and evaluate the effectiveness of ECM services provided including:

3.1.1 Collecting and tracking measures and outcome data to be reported as required in CalAIM Program guide

3.1.2 Reviewing Utilization Metrics

3.1.3 Tracking quality measures including HEDIS metrics

3.1.4 Collecting, analyzing and reporting financial measures

3.1.5 Reviewing Grievance and Appeals

3.1.6 Reporting on the measures listed in the Department of Health Care Services (DHCS) templates for reporting, encounters, and supplemental payment files as well as any supplemental reports requested by DHCS.

3.2 AAH's ECM, Analytics and Quality teams utilize information obtained and incorporate ECM data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through

interventions and education with targeted providers who have unique or outlying issues or identified trends.

4.0 ECM Provider Onsite Visits and Case File Reviews

4.1 AAH ECM Staff perform site visits, when possible, in order to evaluate ECM operational and care management activities.

4.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of ECM Provider activities.

4.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess ECM activities. Onsite visits will assess both operational and care management activities of the ECM Providers.

4.2 Operational areas to be reviewed include:

4.2.1 Staffing, including Care Management Ratios

4.2.2 Reporting and tracking systems

4.2.3 Program development

4.2.4 Staff training

4.3 Case File Review: At the time of a site visit, a random sample of charts, using 8/30 methodology, will be reviewed for evidence of required ECM Care Management services including:

4.3.1 Outreach and engagement

4.3.2 Comprehensive Care Management

4.3.3 Evidence of Health Action Plan (HAP) completion

4.3.4 Participation of the member in HAP development

4.3.5 Participation of Multidisciplinary team

4.3.6 Comprehensive Transitional Care including HAP update

4.3.7 Communication between Care Team members and PCP

4.3.8 Referral Tracking

4.3.9 Referrals to housing support services, when applicable

4.3.10 Referral to Palliative Care, when applicable

4.3.11 Incorporation of Trauma Informed Care practices

4.4 AAH will work collaboratively with ECM Providers in order to identify and address solutions and resolve any areas of deficiency.

4.5 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

4.6 If a CAP is requested and the ECM Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the ECM Provider is meeting ECM program delivery requirements.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HAP	Health Action Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-012 Health Homes – Housing Services
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

A	B	C	D	E	F	G	H	I	J	K	L
		Comprehensive Care Manageme		Health Assessment and Goals						Care Coordination	
Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note:Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?	Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?

Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Refferals to Community & Social Supports
Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointmen	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

	A	B	C	D	E	F	G	H	I	J	K	L
1					Comprehensive Care Manageme		Health Assessment and Goals					
2	Member Name	Member DOB	Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note: Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?

M	N	O	P	Q	R	S
Care Coordination		Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Long-Term Services & Supports	Referrals to Community & Social Supports
Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?	Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointment	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Has the assessment of LTSS and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

Monthly schedule will be established and shared with ECM providers at the beginning of each year for scheduled ECM Provider oversight and monitoring.

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POLICY AND PROCEDURE

Policy Number	CM-013
Policy Name	Enhanced Care Management – Oversight, Monitoring, & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	07/16/2020
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	~~10/19/2023~~TBD

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2.1.1 ECM Provider reports are submitted monthly and are uploaded directly into the AAH SFTP site.

2.2 AAH Analytics team reviews the eligibility and enrollment reports and provides feedback or requests additional information from ECM Providers:

2.2.1 AAH Analytics team reviews data monthly. AAH Analytics team has 30 days upon receipt of report to review submission for content including, but not limited to, use of the correct report template, reporting period and content.

2.2.1.1 If report does not appear to reflect ECM activities, AAH Analytics team follows-up with the contracted ECM Provider to request clarification. AAH Analytics team will work with AAH ECM team and ECM Provider to identify solutions and close gaps.

2.2.1.2 If upon requested clarification additional concerns exist, a Corrective Action Plan (CAP) may be required.

2.2.1.3 If a CAP is requested and the ECM Provider does not meet or is unable to meet CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that ECM Provider is meeting ECM program delivery requirements.

3.0 Quarterly Monitoring of AAH Internal Reports

3.1 AAH collects and tracks operational and clinical data from ECM Providers, as well as internal data in order to manage and evaluate the effectiveness of ECM services provided including:

3.1.1 Collecting and tracking measures and outcome data to be reported as required in CalAIM Program guide

3.1.2 Reviewing Utilization Metrics

3.1.3 Tracking quality measures including HEDIS metrics

3.1.4 Collecting, analyzing and reporting financial measures

3.1.5 Reviewing Grievance and Appeals

3.1.6 Reporting on the measures listed in the Department of Health Care Services (DHCS) templates for reporting, encounters, and supplemental payment files as well as any supplemental reports requested by DHCS.

3.2 AAH's ECM, Analytics and Quality teams utilize information obtained and incorporate ECM data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through

interventions and education with targeted providers who have unique or outlying issues or identified trends.

4.0 ECM Provider Onsite Visits and Case File Reviews

4.1 AAH ECM Staff perform site visits, when possible, in order to evaluate ECM operational and care management activities.

4.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of ECM Provider activities.

4.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess ECM activities. Onsite visits will assess both operational and care management activities of the ECM Providers.

4.2 Operational areas to be reviewed include:

4.2.1 Staffing, including Care Management Ratios

4.2.2 Reporting and tracking systems

4.2.3 Program development

4.2.4 Staff training

4.3 Case File Review: At the time of a site visit, a random sample of charts, using 8/30 methodology, will be reviewed for evidence of required ECM Care Management services including:

4.3.1 Outreach and engagement

4.3.2 Comprehensive Care Management

4.3.3 Evidence of Health Action Plan (HAP) completion

4.3.4 Participation of the member in HAP development

4.3.5 Participation of Multidisciplinary team

4.3.6 Comprehensive Transitional Care including HAP update

4.3.7 Communication between Care Team members and PCP

4.3.8 Referral Tracking

4.3.9 Referrals to housing support services, when applicable

4.3.10 Referral to Palliative Care, when applicable

4.3.11 Incorporation of Trauma Informed Care practices

4.4 AAH will work collaboratively with ECM Providers in order to identify and address solutions and resolve any areas of deficiency.

4.5 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

4.6 If a CAP is requested and the ECM Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the ECM Provider is meeting ECM program delivery requirements.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HAP	Health Action Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-012 Health Homes – Housing Services
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

A	B	C	D	E	F	G	H	I	J	K	L
		Comprehensive Care Manageme		Health Assessment and Goals						Care Coordination	
Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note:Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?	Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?

Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Refferals to Community & Social Supports
Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointmen	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

	A	B	C	D	E	F	G	H	I	J	K	L
1					Comprehensive Care Manageme		Health Assessment and Goals					
2	Member Name	Member DOB	Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note: Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?

M	N	O	P	Q	R	S
Care Coordination		Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Long-Term Services & Supports	Referrals to Community & Social Supports
Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?	Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointment	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Has the assessment of LTSS and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

Monthly schedule will be established and shared with ECM providers at the beginning of each year for scheduled ECM Provider oversight and monitoring.

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POLICY AND PROCEDURE

Policy Number	CM-014
Policy Name	Enhanced Care Management – Operations Non-Duplication
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (AAH) must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving Enhanced Care Management (ECM) care coordination services.

PROCEDURE

1.0 The process to verify member eligibility in other Medi-Cal care coordination services (not ECM) should include:
- 1.1 Checking available AAH data;
- 1.2 Asking members as part of both the in-person/telephonic member assessment during the eligibility/enrollment process and the assessment/care plan process.

2.0 Based on available data, the ECM Eligibility does not include members who are participating in the following programs:
- 2.1 Members enrolled in a program funded by a 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC);
- 2.2 Members in a Skilled Nursing Facility (SNF) with a duration longer than

the month of admission and the following month; and

2.3 Members enrolled in a hospice care setting.

3.0 Below is a summary of how ECM intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: Members can receive services through both ECM and the other program; Members must choose ECM or the other program; and Members cannot receive ECM services.

3.1 Members Can Receive Services through BOTH ECM and the Other Program

3.1.1 California Children's Services

Children who are enrolled in the Children's Services program are eligible for the ECM.

3.1.2 Specialty Mental Health and Drug Medi-Cal

DHCS recognizes that coordination of behavioral health services will be a major component of ECM. ECM services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California ECM structure of Managed Care Plans (MCPs) and ECM Providers, it is expected that direct ECM services for ECM members will primarily occur at the ECM Providers, even though MCPs may play a role.

Therefore, it is important that ECM Providers that have ECM members who receive behavioral health services have the capability to support the various needs of their members.

For ECM members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented ECM Provider is an appropriate setting for their ECM services. These ECM Providers would typically be affiliated with a MCP.

DHCS and stakeholders have noted that ECM members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary ECM services from their Mental Health Provider's (MHP) contracted provider acting as a designated ECM Provider. To facilitate care coordination for ECM members through a MHP-designated ECM Provider, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform ECM Provider ECM responsibilities through a contract with the

MCPs in the county at the discretion of the MCP. This type of entity would perform the ECM Providers ECM responsibilities for an ECM eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated ECM Provider instead of an ECM Provider affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the ECM Provider.

3.1.3 Members maybe enrolled in ECM and receive ILOS services.

4.0 Member Choice: ECM or other case management program

4.1 Targeted Case Management

County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and may be duplicative of ECM. Members who are receiving TCM services have a choice of continuing TCM services or receiving ECM services.

However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of ECM. The ECM Provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

4.2 1915(c) Waiver Programs

1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for ECM. There are comprehensive care management components within these programs that are duplicative of ECM services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.

The 1915(c) HCBS waiver programs include:
HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC).

4.3 Cal MediConnect or Fee-for-Service Delivery Systems
(Note to ECM Providers: This section's language is required by the state of California; Alameda County does not offer the Cal MediConnect program.)

Members who are eligible for both Medi-Cal and Medicare are eligible for the ECM. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the ECM. However, ECM is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for- Service delivery systems to receive all their Medi-Cal services, including ECM services, through a regular Medi-Cal Managed Care Plan.

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Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of ECM services, including programs that are operated or overseen by the MCP. Examples include, but are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

5.0 Members receiving treatment or enrolled in the following programs are not eligible for the ECM:
5.1 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the ECM.
5.2 Hospice

DEFINITIONS / ACRONYMS

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ILOS	In Lieu of Services
DHCS	Department of Health Care Services
HCBS	Home and Community Based
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DMC-ODS	Drug Medi-Cal Organized Delivery system

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

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RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
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CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CM-014 Enhanced Care Management – Operations Non-Duplication

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-014
Policy Name	Enhanced Care Management – Operations Non-Duplication
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	~~10/19/2023~~TBD

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

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RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-016 Enhanced Care Management – Staffing
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HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CM-014 Enhanced Care Management – Operations Non-Duplication

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-016
Policy Name	Enhanced Care Management – Staffing
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1.1 The Enhanced Care Management (ECM) Provider is required to deliver ECM services through a team-based approach through the following core services:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and
6. Referral to Community and Social Supports.

1.2 Contracted ECM teams are multi-disciplinary and include an ECM Director, Clinical Consultant (Primary Care Providers [PCPs] served by the ECM Provider), a Nurse Care Manager, a Behavioral Health Care Manager, a Care Coordinator, and a Community Health Worker. The ECM Provider may add additional staff to the team (e.g. Pharmacist, Dietician) to meet ECM Members' needs.

1.3 The table below describes the roles, functions and minimum credentials of required ECM team members.

Required Team Members	Qualifications	Role
Dedicated Lead Care Manager (ECM Member of by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or	• Oversee provision of ECM services and implementation of Health Action Plan (HAP)

Required Team Members	Qualifications	Role
	nurse	• Offer services where ECM member lives, seeks care or find most easily accessible and within the Managed Care Plan (MCP) guidelines • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma- informed care practices • Work with hospital staff on discharge plan • Engage eligible ECM members • Accompany ECM member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call ECM member to facilitate ECM member visit with the ECM care coordinator
ECM Director (ECM Provider)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (ECM Provider or MCP)	Clinician consultant(s), who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed, to assist care coordinator
Community Health Workers (ECM Provider or by contract) (Recommended but not required)	Paraprofessional or peer Advocate Administrative support to care coordinator	• Engage eligible ECM members • Accompany ECM member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-

Required Team Members	Qualifications	Role
		management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Cal ECM member to facilitate ECM visit with care coordinator • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)

1.4 The aggregate minimum care coordinator ratio requirement is 40:1 for the whole enrolled ECM population in a County as measured at any point in time.

PROCEDURE

2.1. Alameda Alliance for Health (AAH) provides ECM Providers with the multi-disciplinary care team guidance from the Department of Health Care Services (DHCS) CalAIM Program Guide and asks them to attest that their team could meet the care team qualifications and roles.

2.2 The multi-disciplinary care team consists of staff employed by the ECM Providers that provides ECM funded services. The team will primarily be located at the ECM Provider organization unless there is insufficient staffing to provide the full range of ECM duties. AAH may subcontract with other entities to perform these duties. In addition, AAH may provide, or subcontract with another community-based entity to provide, specific ECM Provider duties to assist an ECM Provider to provide the full range of ECM Provider duties.

2.3 AAH requires that ECM Provider care teams *not* based within Federally Qualified Health Centers (FQHC) will partner with the ECM Member's PCP and that licensed clinical social work (LCSW) supervisors or registered nurses (RNs) will provide clinical and programmatic oversight. Non-licensed staff will liaise with community and health plan pharmacist and nurses as needed.

2.4 Job Descriptions for Care Coordination Staff are developed, as appropriate, and submitted as part of the ECM Provider certification application process.

2.5 The ECM Provider uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge to ensure that culturally and linguistically

competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the ECM Provider team in setting goals and participating in his/her care planning. The Member's decisions should drive service needs to be addressed within the written HAP.

2.6 Staffing Ratios and estimated caseloads will be actively managed by AAH through the certification process of ECM Providers as well as on a monthly basis post program launch.

- We will collaborate with our ECM Provider partners to meet the required aggregate minimum care manager ratio of 40:1 for the entire enrolled population. We will work with ECM Provider partners to monitor their staffing ratios.
- We will use tools, such as DHCS assessments and membership information provided by the State, to determine appropriate ECM Provider and internal staffing levels other than care managers to meet ECM member needs.
- We will continuously collaborate with ECM Providers to fill positions to meet the contract requirements and staffing conditions of DHCS.

DEFINITIONS / ACRONYMS

AAH – Alameda Alliance for Health
ECM – Enhanced Care Management
DHCS – Department of Health Care Services
LCSW – Licensed Clinical Social Worker
PCP – Primary Care Provider
HAP – Health Action Plan
MCP – Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

CM-016 Enhanced Care Management – Staffing

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CM-016
Policy Name	Enhanced Care Management – Staffing
Department Name	Health Care Services
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5. Individual and Family Support Services; and
6. Referral to Community and Social Supports.

1.2 Contracted ECM teams are multi-disciplinary and include an ECM Director, Clinical Consultant (Primary Care Providers [PCPs] served by the ECM Provider), a Nurse Care Manager, a Behavioral Health Care Manager, a Care Coordinator, and a Community Health Worker. The ECM Provider may add additional staff to the team (e.g. Pharmacist, Dietician) to meet ECM Members' needs.

1.3 The table below describes the roles, functions and minimum credentials of required ECM team members.

Required Team Members	Qualifications	Role
Dedicated Lead Care Manager (ECM Member of by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or	• Oversee provision of ECM services and implementation of Health Action Plan (HAP)

Required Team Members	Qualifications	Role
	nurse	• Offer services where ECM member lives, seeks care or find most easily accessible and within the Managed Care Plan (MCP) guidelines • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma- informed care practices • Work with hospital staff on discharge plan • Engage eligible ECM members • Accompany ECM member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call ECM member to facilitate ECM member visit with the ECM care coordinator
ECM Director (ECM Provider)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (ECM Provider or MCP)	Clinician consultant(s), who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed, to assist care coordinator
Community Health Workers (ECM Provider or by contract) (Recommended but not required)	Paraprofessional or peer Advocate Administrative support to care coordinator	• Engage eligible ECM members • Accompany ECM member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-

Required Team Members	Qualifications	Role
		management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Cal ECM member to facilitate ECM visit with care coordinator • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)

1.4 The aggregate minimum care coordinator ratio requirement is 40:1 for the whole enrolled ECM population in a County as measured at any point in time.

PROCEDURE

2.1. Alameda Alliance for Health (AAH) provides ECM Providers with the multi-disciplinary care team guidance from the Department of Health Care Services (DHCS) CalAIM Program Guide and asks them to attest that their team could meet the care team qualifications and roles.

2.2 The multi-disciplinary care team consists of staff employed by the ECM Providers that provides ECM funded services. The team will primarily be located at the ECM Provider organization unless there is insufficient staffing to provide the full range of ECM duties. AAH may subcontract with other entities to perform these duties. In addition, AAH may provide, or subcontract with another community-based entity to provide, specific ECM Provider duties to assist an ECM Provider to provide the full range of ECM Provider duties.

2.3 AAH requires that ECM Provider care teams *not* based within Federally Qualified Health Centers (FQHC) will partner with the ECM Member's PCP and that licensed clinical social work (LCSW) supervisors or registered nurses (RNs) will provide clinical and programmatic oversight. Non-licensed staff will liaise with community and health plan pharmacist and nurses as needed.

2.4 Job Descriptions for Care Coordination Staff are developed, as appropriate, and submitted as part of the ECM Provider certification application process.

2.5 The ECM Provider uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge to ensure that culturally and linguistically

competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the ECM Provider team in setting goals and participating in his/her care planning. The Member's decisions should drive service needs to be addressed within the written HAP.

2.6 Staffing Ratios and estimated caseloads will be actively managed by AAH through the certification process of ECM Providers as well as on a monthly basis post program launch.

- We will collaborate with our ECM Provider partners to meet the required aggregate minimum care manager ratio of 40:1 for the entire enrolled population. We will work with ECM Provider partners to monitor their staffing ratios.
- We will use tools, such as DHCS assessments and membership information provided by the State, to determine appropriate ECM Provider and internal staffing levels other than care managers to meet ECM member needs.
- We will continuously collaborate with ECM Providers to fill positions to meet the contract requirements and staffing conditions of DHCS.

DEFINITIONS / ACRONYMS

AAH – Alameda Alliance for Health
ECM – Enhanced Care Management
DHCS – Department of Health Care Services
LCSW – Licensed Clinical Social Worker
PCP – Primary Care Provider
HAP – Health Action Plan
MCP – Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023, 10/19/2023

REFERENCES

CM-016 Enhanced Care Management – Staffing

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CM-018
Policy Name	Enhanced Care Management – Member Notification
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1.1. Alameda Alliance for Health (AAH) is responsible for the development, implementation and distribution of requirements for the Enhanced Care Management (ECM) services and related activities to contracted entities, including member identification and member notification.

1.2. Member Identification: Members are identified through two methodologies:

1.2.1. ECM Eligibility List: Every month, AAH produces an eligibility list based on the defined criteria of the ECM populations of focus.

1.2.2. Self-Referrals: Members may self-refer into ECM at any time by contacting AAH Member Services, ECM Provider, or any AAH Staff. Member's family member(s), guardian, caregiver, and/or authorized support person(s) may also contact AAH Member Services, ECM Provider, or any AAH Staff. Member must provide authorization to speak with someone on their behalf.

1.2.3. AAH has a no wrong door policy. AAH will accept an ECM referral from Primary Care Providers (PCPs), clinics, community, and county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, California Children's Services (CCS), foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

1.2.4. AAH uses a closed loop referral system for all ECM referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

1.2.4.1. For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.

1.2.4.2. Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.

1.3. Member Notification: All eligible members will receive initial and ongoing notification of ECM services, following DHCs guidelines.

1.3.1. Initial and ongoing Member communications regarding the ECM services will be made in accordance with existing AAH policies and procedures for Member communication including consideration of individual Member communication needs.

1.3.2. Members and Providers will be informed of ECM and how to access the program through all usual communication venues listed in the AAH's Marketing & Communications Plan that the Department of Health Care Services (DHCS) approves annually and per AAH policies and procedures. For Providers, these notifications will include the Provider Newsletter, Provider Manual and Quarterly Updates which are all published on AAH's website and Provider Portal. The Quarterly Updates are also printed and mailed to provider offices.

1.3.3. Member communications will be provided in accordance with requirements by DHCS including those for cultural competency and health literacy standards.

1.3.3.1. AAH requires that subcontracted plans (delegates) use the same process for:

1.3.3.1.1. Informing members, family member(s), guardian, caregiver, and/or other authorized support person(s) about ECM, requesting ECM, status of the request and returned communication.

1.3.3.1.2. Implementing presumptive authorization or pre-authorization of ECM

1.3.4. AAH ensures verbal and written communications to the Provider, Member, family member(s), guardian, caregiver, and/or other authorized support person(s) for UM decisions, are provided using the appropriate approved templates and within the UM timeliness standards.

1.3.4.1. For minors, ECM providers will be required to follow the

regulations for minor consent services to obtain, document, and manage the Member's parent/guardian authorization for sharing of Personally Identifiable Information between AAH, ECM and other providers involved in the provision of member care and communicate data sharing authorization preferences back to AAH.

1.3.5. Authorization of Enhanced Care Management (ECM)

1.3.5.1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:

- Routine requests not to exceed 5 days
- Expedited requests not to exceed 72 hours

1.3.6. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:

- Provider notification not to exceed 24 hours (oral or written), after decision
- Written notification to provider and member not to exceed 2 working days, after decision

1.4. Members Transitioning from Health Homes & Whole Person Care (WPC)

1.4.1. AAH will work in conjunction with the WPC Lead Entity to develop a list of expected WPC Care Management-enrolled members who will be transitioning to ECM. Once the final Member Transition List (MTL) has been received from DHCS for all eligible HHP/WPC members, a reconciliation will be done against AAH internal data. AAH and the WPC Lead Entity will then work together and come to agreement on the final list of members to transition, including those members who are enrolled after the MTL is received. These Members will be automatically enrolled into ECM.

PROCEDURE

2.1 Member Notification: AAH Members are notified of the ECM benefit

2.1.1 All eligible AAH Members will be initially notified of ECM as a newly covered service for eligible participants prior to implementation of ECM. Notification will be conducted through a direct mail letter. Information will also be provided in a Member Newsletter as well as the member portal on the AAH Website.

2.1.1 Providers will be notified through provider quarterly material, provider orientation, and provider portal on the AAH website.

2.1.2 Initial notification will include:
- 2.1.2.1 A description of the ECM benefit
- 2.1.2.2 Eligibility criteria
- 2.1.2.3 How to access ECM
- 2.1.2.4 Explanation that participation is voluntary and that Member may opt-out of ECM at any time.

2.1.3 AAH will follow an established procedure to get appropriate regulatory approval before mailing this notification to its Members.

2.1.4 All AAH Members will receive ongoing ECM communication through communications venues listed in AAH's Marketing & Communication Plan that DHCS approves annually. Communication methods include, but are not limited to:
- 2.1.4.1 Mailing
- 2.1.4.2 Website
- 2.1.4.3 Member Handbook (EOC)

2.1.5 Ongoing notification will include:
- 2.1.5.1 A description of the ECM benefit;
- 2.1.5.2 Eligibility Criteria;
- 2.1.5.3 How to access ECM; and
- 2.1.5.4 Explanation that participation is voluntary, and that the Member may discontinue participation at any time

2.1.6 Written and/or telephonic notification of enrolled HHP & WPC members transitioning to ECM will include:
- 2.1.6.1 A description of the ECM benefit;
- 2.1.6.2 Eligibility Criteria;
- 2.1.6.3 How their service will continue under ECM; and,
- 2.1.6.4 Explanation that participation is voluntary, and that the Member may discontinue participation at any time

2.1.7 Should a change in HHP/WPC provider be required when transitioning to ECM, a warm handoff will occur between the providers and the member will be notified. In order to mitigate any adverse impacts on the Member during transition, the Member will be engaged so that they may express their preferences and any additional needs they may have.

2.1.8 Members may change their ECM Provider by contacting AAH Member Services at 1- 877-932-2738 or 1-800-735-2929 (TTY) during normal business hours. AAH will accommodate such requests within thirty (30) days, or as soon as possible to meet the Member's needs. AAH staff will facilitate a warm handoff between ECM Providers.

2.1.9 AAH Member and Provider materials are made available through a variety of communication venues listed in AAH's Marketing & Communication Plan that DHCS approves annually. Applicable materials will be updated to incorporate content describing the ECM benefit including the DHCS template for Evidence of Coverage/Disclosure Form. Content will include describing ECM, providing guidance about where to obtain additional information and

how to refer Members who may be potentially eligible for the ECM.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
DHCS – Department of Health Care Services
TCM – Targeted Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 6/20/2022, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CM-018
Policy Name	Enhanced Care Management – Member Notification
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	10/11/2023
Compliance Committee Approval Date	~~10/19/2023~~TBD

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DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
DHCS – Department of Health Care Services
TCM – Targeted Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
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HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 6/20/2022, 10/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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POLICY AND PROCEDURE

Policy Number	
Policy Name	Child Welfare Liaison
Department Name	Case & Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director of Social Determinants of Health
Line(s) of Business	MCAL, MCARE
Effective Date	TBD
Subcommittee Name	UM Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

The purpose of this policy is to clarify the intent and objectives of the Medi-Cal managed care plan Child Welfare Liaison. It also provides guidance regarding the requirements and expectations in relation to the role and responsibilities of the MCP Child Welfare Liaison.

The Alliance has designated an MCP Welfare Liaison to ensure the needs of members involved in child welfare and foster care are met.

The Alliance is working to build partnerships with specified entities, including county child welfare agencies, and enter (as appropriate) into Memorandums of Understand (MOUs) to coordinate and facilitate the provision of Medically Necessary services to members, share data, and as applicable, avoid the duplication of services where members are served by multiple parties. The MOUs are intended to clarify roles and responsibilities among parties, support local engagement, and facilitate the exchange of information necessary to enable care coordination and improve referrals. The MOU is binding, contractual agreement between the Alliance and county child welfare agencies and outlines the responsibilities and obligations of the Alliance to coordinate and facilitate the provision of services to members, when they are served by multiple parties. The MOU with county child welfare agencies will, at a minimum include all of the MOU provisions required by the MOU contract including designation of a MCP Child Welfare Liaison to coordinate with county child welfare agencies.

Assembly Bill (AB) 2083 (Chapter 815, Statutes of 2018) requires each county to develop and implement an MOU setting forth roles and responsibilities of agencies and other entities, such as regional centers, county offices of education, county child welfare, juvenile

probation, and behavioral health agencies, that serve children and youth in foster care who have experienced server trauma as outlines in the All County Letter No. 19-116/Behavioral Health Information Notice 19-053. The purpose of AB 2083 MOU (i.e. Children and Youth Systems of Care (SOC) MOU) is to ensure that children and youth in foster care receive coordinated, timely, and trauma-informed services. While AB 2083 focuses on children and youth in foster care who have experienced severe trauma, it reflects a priority to build a locally governed interagency or interdepartmental model on behalf of all children and youth across California who have similar needs and who interact with and are served by multiple agencies. A component of these SOC MOUs between counties and other local entities that serve children in child welfare/foster care is the implementation of California's Integrated Core Practice Model (ICPM). The ICPM articulates the shared values, core components, and standards of practice expected when serving California's children, youth, and families. The ICPM establishes leadership behaviors and practices that require individuals and organizations to partner and collaborate with one another and the children and families they serve. This ensures an integrated approach to meet the needs of children and families.

These efforts are integral to driving the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of California's most vulnerable populations by implementing broad delivery system, program and payment reforms across the Medi-Cal program, including by establishing Enhanced Care Management (ECM) and Community Supports. Children and Youth Involved in Child Welfare is one of the key Populations of Focus for these efforts.

The BH-CONNECT demonstration is a new Medicaid Section 1115 Demonstration, with an expected effective date of January 1, 2025. It seeks to expand access to and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. BH-CONNECT includes several components that required Centers for Medicare & Medicaid Services (CMS) waiver approval, and others that will be accomplished under existing or other authority, including the implementation of a MCP Child Welfare Liaison within the Alliance.

PROCEDURE

1. Overview

The Alliance has designated an appropriate number of staff to serve as the Alliance Child Welfare Liaison to meet the health care needs of children and youth involved in child welfare in Alameda County.

- 1.1. Children and youth involved in child welfare refers to any member eligible for the ECM Population of Focus for Children and Youth Involved in Child Welfare
- 1.2. Additional Alliance Child Welfare Liaisons will be designated as needed to ensure the health care needs of children and youth involved in child welfare are met and will be commensurate to the number of members involved in child welfare enrolled with the Alliance.
- 1.3. The Alliance has fulfilled the Alliance Child Welfare Liaison role with adequate staffing, and will reassess staffing levels at regular intervals to ensure effectiveness and their ability to serve children and youth involved in child welfare and the geographical landscape of Alameda County.
    - 1.3.1. This includes ensuring sufficient staffing commensurate with the workload necessary to support the care managers.

1.3.2. The Alliance will report on the staffing designated to the Child Welfare Liaison role.

2. Roles and Responsibilities

2.1. Roles

The Alliance Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these members are met.

2.1.1. The Alliance Child Welfare liaison serves as a leader within the Alliance to advocate on behalf of the children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific systematic and operational obstacles for accessing services.

2.1.2. The Alliance Welfare Liaison provides assistance and resources to staff responsible for the member's care coordination, including ECM Lead Care Managers for the Children and Youth Involved in Child Welfare Population of Focus and county child welfare staff such as Health Care Program for Children in Foster Care, public health nurses, and other staff as needed.

2.1.3. The Alliance Child Welfare Liaison is not intended to duplicate care coordination activities provided to members by other providers and staff members, but rather to support and act as a resource to solve escalated issues regarding Alliance services as they arise.

2.2. Responsibilities

2.3. The roles and responsibilities of the Alliance Child Welfare Liaison include, but are not limited to:

2.3.1. Act as a resource and provide technical assistance for staff involved in the coordination of the member's care to ensure escalated issues are resolved; in that Alliance Covered Services, including Medically Necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (Medi-Cal for Kids and Teens), are closely coordinated with other Medi-Cal programs that are carved-out from the Alliance, such as Specialty Mental Health Services as well as other non-Medi-Cal services and benefits such as County Child Welfare Services overseen by the California Department of Social Services.

2.3.2. Individuals who may request assistance from the Alliance Child Welfare Liaison may include, but are not limited to:

2.3.2.1. The member's designated ECM Lead Care Manager who is responsible for coordinating all aspects of ECM and Community Supports as a part of the member's multi-disciplinary care team. The ECM Lead Care Manager serves as the primary point of contact for member and/or parent, caregiver, legal guardian, resource parents, other family member(s)

and/or other authorized support person(s) and coordinates with other staff responsible for coordinating the member's care and the Alliance' Child Welfare Liaison, as needed.

2.3.2.2. County child welfare staff and other county staff responsible for coordinating the member's care including, but not limited to:

2.3.2.2.1. Health Care Program for Children in Foster Care public health nurses
2.3.2.2.2. County probation officers
2.3.2.2.3. County child welfare social workers
2.3.2.2.4. County behavioral health providers
2.3.2.2.5. California Wraparound care coordinators
2.3.2.2.6. County health education specialists
2.3.2.2.7. Child and Family Teams facilitators, and
2.3.2.2.8. Other county child welfare staff, county staff, secondary case managers, and/or other service providers, as applicable.

2.3.2.3. Other staff who may be responsible for coordinating the member's care, including, but not limited to:

2.3.2.3.1. MCP Providers
2.3.2.3.2. Indian Health Care Providers
2.3.2.3.3. Tribes, in the case of an American Indian member
2.3.2.3.4. Community Health Workers
2.3.2.3.5. Regional Center staff, and
2.3.2.3.6. Other secondary case managers and/or service providers, as applicable

2.3.2.4. County Liaisons designated in the MOU between the Alliance and county child welfare agencies, as the county's designated point of contact responsible for acting as the liaison between the county and the Alliance.

2.3.3. Serve as a point of contact for staff to resolve escalated issues in a timely manner when members are experiencing difficulty accessing services, obtaining referrals, changing Providers, or facing operational obstacles to receiving health care services. For example, if a member faces delays in obtaining needed services and supports from the Alliance, such as needed assistance with finding an appropriate Primary Care Provider, the Alliance Child Welfare Liaison may assist staff, such as

county child welfare staff in navigating the health care system on behalf of members involved in child welfare.

2.3.4. Collaborate with the Alliance ECM staff to ensure that robust and effective referral pathway exists to ensure all children and youth involved with child welfare are eligible for the ECM benefit are offered and/or enrolled in the ECM program, including but not limited to referral pathways with the entities listed above who are serving these children and youth.

2.3.5. Provide resources and support regarding Alliance member enrollment and disenrollment when they are made aware that the member will move to a different county. Support may include providing information about how to report a change of address to county social services departments and how to contact the Medi-Cal Managed Care Ombudsman as needed to expedite disenrollment from the Alliance in the county from which the member is leaving.

2.3.6. Assist with benefits and services navigation and coordination throughout the Alliance's service area, including but not limited to ECM, Community Supports, Behavioral Health, Transitional Care Services, Health Education, Home and Community Based Services, California Children's Services (CCS), tribal health care and other local service area resources, etc., to provide full-spectrum services to members.

2.3.7. Coordinate with other internal Alliance Liaisons related to specific member populations and services or programs (e.g., liaisons for Long-Term Services and Supports, Transportation, CCS, Regional Center, Dental, and In-Home Supportive Services). In particular, the Alliance Child Welfare Liaison will coordinate with the designated tribal liaison for members who are American Indian children and youth involved in child welfare.

2.3.8. If applicable, coordinate with the designated MCP County Liaison, which serves as the Alliance's designated point of contact via the MOU between the Alliance and county child welfare agencies. The MCP County Liaison and the Alliance Child Welfare Liaison roles may be the same individual(s), as appropriate and with proper fulfillment of the respective roles.

2.3.9. Attend quarterly meetings with local county child welfare agencies as required, including subsequent updates, and as outlined in the MOU between the MCP and county child welfare agencies, to address care coordination, quality improvement activities, quality improvement outcomes, systemic and case-specific concerns, and communicate with others within their organizations about such activities.

2.3.10. Participate in and provide input for quality improvement activities associated with the MOU between the Alliance and county child welfare agencies.

2.3.11. As applicable, pursuant to the MOU between the Alliance and county child welfare agencies, collaborate with the MCP County Liaison to ensure compliance with the training and education provisions of the MOU, which includes providing training and/or educational materials to county child welfare agencies on how the MCP's Covered Services, and any carved-out services, may be accessed, including during nonbusiness hours.

2.3.12. Provide resources and support to Alliance staff and providers in understanding the Foster Youth Bill of Rights.

2.3.13. Support Alliance staff and providers with using trauma-informed approaches when interacting with children, youth, non-minor dependents, parents, family members, legal guardians, resource parents, or caregivers.

2.4. Additionally, the Alliance Child Welfare Liaison(s) are committed to the following activities to enhance relationships between the Alliance and county child welfare agencies for members involved in child welfare.

2.5. Participate in the MCP Community Advisory Committee and other Alliance committees and meetings that potentially impact members involved in child welfare and foster care.

2.6. As applicable, collaborate with the county to identify opportunities for coordination of and alignment with the county's Interagency Leadership Team's efforts in implementing the AB 2083 SOC MOU, and participate in the SOC Local Interagency Leadership Team meetings to which the Alliance may be invited.

2.7. Collaborate with the other Alliance Child Welfare Liaisons internally and with MCP Child Welfare Liaisons in other MCPs to discuss best practices, lessons learned, and sharing of information and resources.

The Alliance has designated individual(s) for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities as outlined above.

2.8. Criteria for the Alliance Child Welfare Liaison(s):

2.8.1. Have expertise, demonstrable experience, or sufficient training in the following:

2.8.1.1. Child welfare services and county behavioral health services

2.8.1.2. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes.

2.8.1.3. Trauma informed care practices

2.8.2. Additional expertise, experience, and training the Alliance may considered to include, but not limited to:

2.8.2.1. Have a master's degree and/or other additional training in social work, public health nursing, or another related field

2.8.2.2. Have familiarity with Medi-Cal enrollment and disenrollment processes as well as county social services agency processes for updating addresses and other eligibility information

2.8.2.3. Have experience or training in coordinating care within child welfare services and juvenile justice systems and have an understanding of the Foster Care Bill of Rights

3. Information Sharing

3.1. In compliance with the requirement set forth in the appropriate APL(s), including subsequent updates, and the County Social Services Agencies for Child Welfare MOU template, the Alliance has policies and procedures for supporting the timely and frequent exchange of member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining member consent.

3.2. The Alliance will share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other state and federal privacy laws. For additional guidance related to sharing members' data and information.

4. Notification

4.1. In accordance with the MOU between the MCP and county child welfare agencies and the MCP Contract, the Alliance will notify the county child welfare agency and DHCS of a change in the designated MCP Child Welfare Liaison as soon as practicable, but no later than five (5) working days of the change.

4.2. To support collaboration efforts, the California Department of Social Services (DSS) has created a contact list of the County Child Welfare agencies points of contact.

5. DHCS Monitoring

5.1. The Alliance has submitted the MCP Child Welfare Liaison contact information to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD) - MCP Submission Portal.

5.2. With delegated subcontractors that serve children and youth involved with child welfare, the Alliance will submit contact information of the subcontractor's Child Welfare Liaison(s) to the MCOD-MCP Submission Portal.

5.2.1. The Alliance is responsible for ensuring subcontractors' compliance with the requirements.

5.2.2. The Alliance is responsible for ensuring subcontrators and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

DEFINITIONS / ACRONYMS

MCP – Managed Care Plan
MOU – Memorandum of Understanding
AB – Assembly Bill
CalAIM - California Advancing and Innovating Medi-Cal
BH-CONNECT - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
CMS - Centers for Medicare & Medicaid Services
ECM – Enhanced Care Management
CCS - California Children's Services
SOC - Systems of Care
EPSDT - Early and Periodic Screening, Diagnostic and Treatment
HIPAA - Health Insurance Portability and Accountability Act

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management
Enhanced Care Management

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

REFERENCES

APL 24-013

MONITORING

[Describe the supervising activities in progress to ensure they are on-course and on-schedule in meeting the objectives and performance targets of this policy.]

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	G&A-001
Policy Name	Grievance and Appeals System Description
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	08/24/2017
Approval/Revision Date	~~3/31/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has established and maintained a grievance and appeals system in which the member or an authorized representative submit their grievance or appeal to the Alliance. The grievance and appeals system provides reasonable procedures in accordance with applicable regulations that ensure adequate consideration of the filed grievance or appeal and rectification when appropriate. The Alliance ensures that each issue is addressed and resolved when a complainant presents with multiple issues.

The grievance and appeals system is established in writing and provides procedures for receiving, reviewing and resolving grievance and appeals within 30 calendar days of receipt by the Alliance, or our delegated entities that administer and resolve member grievance and appeals.

PROCEDURE

1. Designation of Plan Officer

The Chief Medical Officer maintains primary responsibility for the Alliance's grievance and appeals system and for the grievance and appeals system delegated to our delegated entities. The officer continuously reviews the operation of the grievance and appeals system to identify any emergent patterns of grievance and appeals as well as reporting procedures to improve plan policies and procedures.

2. Linguistic and Cultural Needs

The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

3. Filing a Grievance or Appeal

Grievance and appeals may be filed either orally or in writing by the member or an authorized representative. Grievance and appeals are received by telephone via our local telephone number or our toll-free telephone number, by facsimile, by e-mail, or online through the Alliance's website pursuant of CA Health and Safety Code §1368.015 (see G&A-002 Grievance Filing)

The Alliance provides a prompt review of grievance and appeals by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

Grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the standard grievance system (see MBR-024 Exempt Grievances). The Alliance maintains a periodically reviewed log of all exempt grievances which includes:

- The date of the call,
- The name of the complainant,
- The complainant's member identification number;
- The nature of the grievance;
- The nature of the resolution; and
- The name of the Alliance representative who took the call and resolved the grievance.

The Alliance does not discourage the filing of grievances. A member does not need to use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. When the member expressly declines to file a Grievance, the complaint will still be categorized as a Grievance and not an inquiry. The Alliance protects the identity of the member, and the complaint is still aggregated for tracking and trending purposes as with other Grievances.

4. Written Record of a Grievance or Appeal

The Alliance creates a written record for each grievance and appeal received; including the date and time received, the name of the member filing, the Alliance representative recording the grievance or appeal, a description of the complaint or problem, a description of the action taken by the Alliance or provider to investigate and resolve, the proposed resolution by the Alliance or provider, the name of the Alliance provider or staff responsible for resolving, and the date of notification t the member of resolution.

The written records are reviewed monthly by the Board of Governors, quarterly by the public policy body, quarterly by the Internal Quality Improvement Committee for systematic

aggregation and analysis for quality improvement and periodically by the Chief Medical Officer. The grievance and appeals reviewed include, but not limited to, those related to access to care, quality of care, and denial of services. Appropriate action is taken to remedy any problems identified and are thoroughly documented in meeting minutes.

Copies of the grievances and responses are maintained by the Alliance for five (5) years, and include a copy of all medical records, documents, evidence of coverage and other relevant information in which the Alliance relied on in reaching a decision.

5. No Discrimination

The Alliance ensures that there is no discrimination against a member on the grounds that the complainant filed a grievance.

6. Quarterly Reports

a. Department of Health Care Services (DHCS)

The Alliance submits quarterly reports for grievances and appeals following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

b. Department of Managed Health Care (DMHC)

The Alliance submits a quarterly report to the Department that describes grievances that were or are pending and unresolved for 30 days or more. The report is prepared for the quarters ending March 31st, June 30th, September 30th, September 30th and December 31st of each calendar year. The report contains the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the Alliance as of the last day of each quarter.

The quarterly reports include:

- The licensee's name, quarter and date of the report;
- The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan'
- A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
- The nature of the unresolved grievances as (1) coverage dispute; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for

appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.
- The quarterly report shall not contain personal or confidential information with respect to any enrollee.

The quarterly report is verified by an officer authorized to act on behalf of the Alliance. The report is submitted through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report is not filed as an amendment to the Alliance application.

7. Filing a Grievance with DMHC

A member may submit a grievance to the Department. The Alliance will provide the following information to the Department within five (5) calendar days after notification by the Department:

- A written response to the issues raised by the grievance;
- A copy of the Alliance's original response sent to the member with regards to the grievance;
- A complete and legible copy of all medical records related to the grievance, the Alliance will inform the Department if medical records were not used by the Alliance in resolving the grievance;
- A copy of the cover page and all relevant pages of the member's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the Alliance relied solely on the EOC, the Alliance will notify the Department of that fact; and
- All other information used by the Alliance or relevant to the resolution of the grievance.

The Department may request additional information or medical records from the Alliance; the Alliance will forward the requested information and records that are maintained by the Alliance or any contracting provider within five (5) calendar days of receipt of the Department's request. If the requested information cannot be forwarded timely to the Department, the Alliance's response will describe the actions being taken to obtain the information or records and when the receipt is expected.

DEFINITIONS / ACRONYMS

1. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, other than an Adverse Benefit Determination made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
2. "Complaint" is the same as "grievance."
3. An "Inquiry" is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Alliance processes.
4. "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

5. "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
    a. If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.
    b. Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals
- Utilization Management
- Quality Improvement
- Compliance
- Provider Relations
- Member Services

RELATED POLICIES AND PROCEDURES

- G&A-002 Grievance Filing
- G&A-003 Grievance and Appeals Receipt, Review and Resolution
- G&A-004 Member Education/Notification Requirements
- G&A-005 Expedited Review of Urgent Grievance and Appeals
- G&A-006 Independent Medical Review
- G&A-007 State Fair Hearing
- G&A-008 Adverse Benefit Determination Appeals Process
- MBR-024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance and Appeals Intake Workflow
- Expedited Appeal Check List
- Standard Appeal Check List
- Expedited Grievance Check List
- Standard Grievance Check List
- DMHC Quarterly Report of Pending and Unresolved Grievances Template
- DHCS Quarterly Grievance and Appeals Report Template
- DMHC RHPI Check List
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

03/01/2018, 04/12/2018, 11/15/2018, 05/19/2020, 01/21/21, 11/18/21, 3/31/2023

REFERENCES

- CA Health and Safety Code section 1367.01(j)
- CA Health and Safety Code section 1368(a)(1),(4)(B)
- 28 CCR 1300.68(a),(b)(1)(3)(5) and (8),(d)(2)(6) and (8),(e),(f)(1), (g)
- DHCS All Plan Letter 21-011
- DHCS All Plan Letter 20-017
- NCQA ME 7: Member Experience
    - Element A: Policies and Procedures for Complaints
    - Element B: Policies and Procedures for Appeals

MONITORING

1. Internal Reporting

The Alliance maintains a system of aging of Grievance and Appeals that are pending and unresolved for 30 days or more and shall include a brief explanation of the reasons each Grievance and Appeal is pending and unresolved. Aging reports are reviewed daily to ensure cases do not exceed their required turnaround timeframe.

The Alliance maintains a process for evaluating complaints, assessing trends, implementing actions to correct identified problems, having mechanisms to communicate actions and results to the appropriate employees and contracted providers, and having provisions for evaluation of any corrective action plan and measurements of performance.

Grievance and Appeals are reporting to the following bodies:

- Monthly Board of Governors
- Quarterly Member Advisory Committee (Public Policy Body)
- Quarterly Health Care Quality Committee
- Quarterly Internal Quality Improvement Committee
- Quarterly Access and Availability Committee
- Quarterly Utilization Management Committee
- Quarterly Cultural and Linguistic Committee

2. Internal Auditing

Auditing is conducted on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;

e. The audit findings are also reporting during the quarterly Compliance Committee.

3. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

4. Regulatory Reporting

The grievance system tracks and monitors all grievances received by the Alliance, and our Delegated Entities with authority to receive and respond to grievances.

Monitoring is done on all grievances received and resolved, whether the grievance was resolved in favor of the member or Plan; and the number of grievances pending over 30 calendar days.
Grievances are tracked under the following categories:

- Commercial;
- Medicare; and
- Medi-Cal/other contracts.

Grievances that are pending over 30 calendar days are captured as being pended within the following processes:

- The Alliance's internal grievance system;
- The Department's consumer complaint process;
- The Department's IMR system;
- An action filed or before a trial or appellate court; or
- Other dispute resolution process.

Grievances that have been submitted to:

- The Medicare review and appeal system;
- The Medi-Cal fair hearing process; or
- Arbitration.

Grievances are indicated by the total number of grievances received, pending and resolved in favor of the member at all levels of grievance review and to describe the issue or issues raised in grievances as:

- Coverage disputes;
- Disputes involving medical necessity,
- Complaints about the quality of care and,
- Complaints about access to care (including complaints about the waiting time for appointments), and
- Complaints about the quality of service, and
- Other issues.

5. Delegation Oversight of Grievance and Appeals

The Grievance and Appeals Unit reviews routine regulatory and contractual reports for tracking and trending grievances, and issues corrective action plans to delegates when deficiencies are found.

Delegate's grievance system is audited annually to review policies and procedures, conduct file review to ensure all regulatory and contractual requirements are met for processing grievance and appeals and follow-up on any issues found within the calendar year with delegation reporting and/or other operational issues.

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POLICY AND PROCEDURE

Policy Number	G&A-001
Policy Name	Grievance and Appeals System Description
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	08/24/2017
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has established and maintained a grievance and appeals system in which the member or an authorized representative submit their grievance or appeal to the Alliance. The grievance and appeals system provides reasonable procedures in accordance with applicable regulations that ensure adequate consideration of the filed grievance or appeal and rectification when appropriate. The Alliance ensures that each issue is addressed and resolved when a complainant presents with multiple issues.

The grievance and appeals system is established in writing and provides procedures for receiving, reviewing and resolving grievance and appeals within 30 calendar days of receipt by the Alliance, or our delegated entities that administer and resolve member grievance and appeals.

PROCEDURE

1. Designation of Plan Officer

The Chief Medical Officer maintains primary responsibility for the Alliance's grievance and appeals system and for the grievance and appeals system delegated to our delegated entities. The officer continuously reviews the operation of the grievance and appeals system to identify any emergent patterns of grievance and appeals as well as reporting procedures to improve plan policies and procedures.

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The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

3. Filing a Grievance or Appeal

Grievance and appeals may be filed either orally or in writing by the member or an authorized representative. Grievance and appeals are received by telephone via our local telephone number or our toll-free telephone number, by facsimile, by e-mail, or online through the Alliance's website pursuant of CA Health and Safety Code §1368.015 (see G&A-002 Grievance Filing)

The Alliance provides a prompt review of grievance and appeals by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.

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- The date of the call,
- The name of the complainant,
- The complainant's member identification number;
- The nature of the grievance;
- The nature of the resolution; and
- The name of the Alliance representative who took the call and resolved the grievance.

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4. Written Record of a Grievance or Appeal

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The written records are reviewed monthly by the Board of Governors, quarterly by the public policy body, quarterly by the Internal Quality Improvement Committee for systematic

aggregation and analysis for quality improvement and periodically by the Chief Medical Officer. The grievance and appeals reviewed include, but not limited to, those related to access to care, quality of care, and denial of services. Appropriate action is taken to remedy any problems identified and are thoroughly documented in meeting minutes.

Copies of the grievances and responses are maintained by the Alliance for five (5) years, and include a copy of all medical records, documents, evidence of coverage and other relevant information in which the Alliance relied on in reaching a decision.

5. No Discrimination

The Alliance ensures that there is no discrimination against a member on the grounds that the complainant filed a grievance.

6. Quarterly Reports

a. Department of Health Care Services (DHCS)

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b. Department of Managed Health Care (DMHC)

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The quarterly reports include:

- The licensee's name, quarter and date of the report;
- The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan'
- A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
- The nature of the unresolved grievances as (1) coverage dispute; (2) disputes involving medical necessity; (3) complaints about the quality of care; (4) complaints about access to care (including complaints about the waiting time for

appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.
- The quarterly report shall not contain personal or confidential information with respect to any enrollee.

The quarterly report is verified by an officer authorized to act on behalf of the Alliance. The report is submitted through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report is not filed as an amendment to the Alliance application.

7. Filing a Grievance with DMHC

A member may submit a grievance to the Department. The Alliance will provide the following information to the Department within five (5) calendar days after notification by the Department:

- A written response to the issues raised by the grievance;
- A copy of the Alliance's original response sent to the member with regards to the grievance;
- A complete and legible copy of all medical records related to the grievance, the Alliance will inform the Department if medical records were not used by the Alliance in resolving the grievance;
- A copy of the cover page and all relevant pages of the member's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the Alliance relied solely on the EOC, the Alliance will notify the Department of that fact; and
- All other information used by the Alliance or relevant to the resolution of the grievance.

The Department may request additional information or medical records from the Alliance; the Alliance will forward the requested information and records that are maintained by the Alliance or any contracting provider within five (5) calendar days of receipt of the Department's request. If the requested information cannot be forwarded timely to the Department, the Alliance's response will describe the actions being taken to obtain the information or records and when the receipt is expected.

DEFINITIONS / ACRONYMS

1. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, other than an Adverse Benefit Determination made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
2. "Complaint" is the same as "grievance."
3. An "Inquiry" is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Alliance processes.
4. "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

5. "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
    a. If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.
    b. Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending" grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals
- Utilization Management
- Quality Improvement
- Compliance
- Provider Relations
- Member Services

RELATED POLICIES AND PROCEDURES

- G&A-002 Grievance Filing
- G&A-003 Grievance and Appeals Receipt, Review and Resolution
- G&A-004 Member Education/Notification Requirements
- G&A-005 Expedited Review of Urgent Grievance and Appeals
- G&A-006 Independent Medical Review
- G&A-007 State Fair Hearing
- G&A-008 Adverse Benefit Determination Appeals Process
- MBR-024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance and Appeals Intake Workflow
- Expedited Appeal Check List
- Standard Appeal Check List
- Expedited Grievance Check List
- Standard Grievance Check List
- DMHC Quarterly Report of Pending and Unresolved Grievances Template
- DHCS Quarterly Grievance and Appeals Report Template
- DMHC RHPI Check List
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

03/01/2018, 04/12/2018, 11/15/2018, 05/19/2020, 01/21/21, 11/18/21, 3/31/2023

REFERENCES

- CA Health and Safety Code section 1367.01(j)
- CA Health and Safety Code section 1368(a)(1),(4)(B)
- 28 CCR 1300.68(a),(b)(1)(3)(5) and (8),(d)(2)(6) and (8),(e),(f)(1), (g)
- DHCS All Plan Letter 21-011
- DHCS All Plan Letter 20-017
- NCQA ME 7: Member Experience
    - Element A: Policies and Procedures for Complaints
    - Element B: Policies and Procedures for Appeals

MONITORING

1. Internal Reporting

The Alliance maintains a system of aging of Grievance and Appeals that are pending and unresolved for 30 days or more and shall include a brief explanation of the reasons each Grievance and Appeal is pending and unresolved. Aging reports are reviewed daily to ensure cases do not exceed their required turnaround timeframe.

The Alliance maintains a process for evaluating complaints, assessing trends, implementing actions to correct identified problems, having mechanisms to communicate actions and results to the appropriate employees and contracted providers, and having provisions for evaluation of any corrective action plan and measurements of performance.

Grievance and Appeals are reporting to the following bodies:

- Monthly Board of Governors
- Quarterly Member Advisory Committee (Public Policy Body)
- Quarterly Health Care Quality Committee
- Quarterly Internal Quality Improvement Committee
- Quarterly Access and Availability Committee
- Quarterly Utilization Management Committee
- Quarterly Cultural and Linguistic Committee

2. Internal Auditing

Auditing is conducted on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;

e. The audit findings are also reporting during the quarterly Compliance Committee.

3. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

4. Regulatory Reporting

The grievance system tracks and monitors all grievances received by the Alliance, and our Delegated Entities with authority to receive and respond to grievances.

Monitoring is done on all grievances received and resolved, whether the grievance was resolved in favor of the member or Plan; and the number of grievances pending over 30 calendar days.
Grievances are tracked under the following categories:

- Commercial;
- Medicare; and
- Medi-Cal/other contracts.

Grievances that are pending over 30 calendar days are captured as being pended within the following processes:

- The Alliance's internal grievance system;
- The Department's consumer complaint process;
- The Department's IMR system;
- An action filed or before a trial or appellate court; or
- Other dispute resolution process.

Grievances that have been submitted to:

- The Medicare review and appeal system;
- The Medi-Cal fair hearing process; or
- Arbitration.

Grievances are indicated by the total number of grievances received, pending and resolved in favor of the member at all levels of grievance review and to describe the issue or issues raised in grievances as:

- Coverage disputes;
- Disputes involving medical necessity,
- Complaints about the quality of care and,
- Complaints about access to care (including complaints about the waiting time for appointments), and
- Complaints about the quality of service, and
- Other issues.

5. Delegation Oversight of Grievance and Appeals

The Grievance and Appeals Unit reviews routine regulatory and contractual reports for tracking and trending grievances, and issues corrective action plans to delegates when deficiencies are found.

Delegate's grievance system is audited annually to review policies and procedures, conduct file review to ensure all regulatory and contractual requirements are met for processing grievance and appeals and follow-up on any issues found within the calendar year with delegation reporting and/or other operational issues.

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POLICY AND PROCEDURE

Policy Number	G&A – 002
Policy Name	Grievance Filing
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	03/01/2018
Approval/Revision Date	~~10/19/2023~~11/15/2024

POLICY STATEMENT

The Alliance maintains a toll-free/local telephone number and an online form through its web site that members can use for filing grievances with the Alliance.

PROCEDURE

1. The Alliance's internet web site has an easily accessible online grievance submission procedure as outlined in the attached Filing a Grievance Online Member Guide. The online submission is accessible through a hyperlink labeled Grievance Form on the Alliance's Member Services Portal web site page which is accessed through the Alliance's homepage, all information submitted through the member services portal is supported by a secure server.

2. The Alliance's online grievance submission process includes the following requirements:
    a. It utilizes an online grievance form in HTML format that allows the complainant to enter required information directly into the form;
    b. It allows the complainant to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal; and
    c. It includes a current hyperlink to the California Department of Managed Health Care Web site, and includes a statement in a legible size and type, containing the required disclosure in accordance with Health and Safety Code section 1368.02(b).

3. Grievance Disclosure

The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

4. Linguistic and Cultural Needs

The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

In the case of a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, DHCS has determined that adequate notice means notice in the member's selected alternative format, or notice that is otherwise in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973, and Government Code Section 11135. The Alliance may not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes.

The Alliance must calculate the deadline for a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

5. Assistance in Filing a Grievance

The Alliance's grievance system provides assistance in filing grievances at each location where a grievance may be submitted through the attached grievance form. A "patient advocate" or ombudsperson may also be used in assistance in filing a grievance. The grievance form and a description of the grievance procedure is readily available at the

Alliance, on the Alliance's web site, and from each contracting provider's office or facility. Grievance forms are provided promptly upon request.

DEFINITIONS / ACRONYMS

1. "Homepage" means the first page or welcome page of an Internet Web site that serves as a starting point for navigation of the Internet Web site.
2. "HTML" means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a Web document.
3. "Hyperlink" means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another Internet Web site or Web page.
4. "Member services portal" means the first page or welcome page of an Internet Web site that can be reached directly by the Internet Web site's homepage and that serves as a starting point for a navigation of member services available on the Internet Web site.
5. "Secure server" means an Internet connection to an Internet Web site that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.
6. "URL" or "Uniform Resource Locator" means the address of an Internet Web site or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the Internet Web site or the resource.
7. "Internet Web site" means a site or location on the World Wide Web.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Information Technology Department
- Member Services Department
- Provider Relations Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance Form
- Evidence of Coverage
- "Your Rights"
- Grievance and Appeals General Information – AAH Website
- Filing a Grievance Online Member Guide
- Retrieving Online Grievances Guide

REVISION HISTORY

03/01/2018, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368.015
- CA Health and Safety Code section 1368.016
- CA Health and Safety Code section 1368.02(b)
- 28 CCR 1300.68(b)(3),(4),(6) and (7)
- Assembly Bill No. 1802
- All Plans Letter 22-002

MONITORING

1. Provider Education

   Provider education is conducted through our New Provider Orientation Presentation, on a quarterly basis through provider newsletters, and on an ad-hoc basis when required by the Provider Relations Department. Education consists of a description of the grievance procedures as well as a review of the grievance form.

2. Staff Training

   Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Grievance and Appeals. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A – 002
Policy Name	Grievance Filing
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	03/01/2018
Approval/Revision Date	11/15/2024

POLICY STATEMENT

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The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

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In the case of a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, DHCS has determined that adequate notice means notice in the member's selected alternative format, or notice that is otherwise in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973, and Government Code Section 11135. The Alliance may not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes.

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The Alliance's grievance system provides assistance in filing grievances at each location where a grievance may be submitted through the attached grievance form. A "patient advocate" or ombudsperson may also be used in assistance in filing a grievance. The grievance form and a description of the grievance procedure is readily available at the

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AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Information Technology Department
- Member Services Department
- Provider Relations Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance Form
- Evidence of Coverage
- "Your Rights"
- Grievance and Appeals General Information – AAH Website
- Filing a Grievance Online Member Guide
- Retrieving Online Grievances Guide

REVISION HISTORY

03/01/2018, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368.015
- CA Health and Safety Code section 1368.016
- CA Health and Safety Code section 1368.02(b)
- 28 CCR 1300.68(b)(3),(4),(6) and (7)
- Assembly Bill No. 1802
- All Plans Letter 22-002

MONITORING

1. Provider Education

   Provider education is conducted through our New Provider Orientation Presentation, on a quarterly basis through provider newsletters, and on an ad-hoc basis when required by the Provider Relations Department. Education consists of a description of the grievance procedures as well as a review of the grievance form.

2. Staff Training

   Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Grievance and Appeals. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-003
Policy Name	Grievance and Appeals Receipt, Review and Resolution
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	08/24/2017
Approval/Revision Date	~~03/31/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") shall receive, review and resolve grievances and appeals within the required timeframes set forth by Department of Managed Health Care (Department) state regulations, Department of Health Care Services (DHCS) contractual obligations and National Committee for Quality Assurance (NCQA) accreditation standards.

PROCEDURE

1. Timeframes for Filing

    a. The Alliance will allow the complainant at least 180 calendar days from the date of the incident or action that is the subject of the member's dissatisfaction to file a grievance for our GroupCare members; and
    b. The Alliance will allow the complainant any time to file a grievance about an incident or action that is subject of the member's dissatisfaction for our Medi-Cal members.

2. Grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the standard grievance system (see MBR-024 Exempt Grievances). The Alliance maintains a periodically reviewed log of all exempt grievances which includes:

    - The date of the call,
    - The name of the complainant,

- The complainant's member identification number;
- The nature of the grievance;
- The nature of the resolution; and
- The name of the Alliance representative who took the call and resolved the grievance.

3. Written Record of a Grievance or Appeal

The Alliance creates a written record for each grievance and appeal received; including the date and time received, the name of the member filing, the Alliance representative recording the grievance or appeal, a description of the complaint or problem, a description of the action taken by the Alliance or provider to investigate and resolve, including, but not limited to the member's previous complaint history and follow-up activities associated with the complaint, the proposed resolution by the Alliance or provider, the name of the Alliance provider or staff responsible for resolving, and the date of notification to the member of resolution.

4. Acknowledgment of a Grievance or Appeal

The Alliance provides a written acknowledgement that is dated and postmarked within five (5) calendar days of receipt. A written Acknowledgment to the complainant advises that the grievance has been received, the date of receipt, and provides the name, telephone number and address of the coordinator who was assigned the case and who may be contacted about the grievance.

5. Resolution of a Grievance or Appeal

a. The Alliance investigates the content of the complaint, including all issues relevant to the complaint, and documents all findings as part of the resolution.
b. The Alliance provides a written resolution within thirty (30) calendar days of receipt. The resolution contains a clear and concise explanation of the Alliance's decision.
    i. For those members in a Skilled Nursing Facility, a copy of the notification will also be provided to the Skilled Nursing Facility in which the member resides.
c. In the event a resolution is not reached within 30-calendar days, the Alliance will notify the complainant in writing that the complaint was received, investigated, and of the status of the grievance and provide an estimated completion date of resolution.
d. The Alliance ensures the participation of individuals with authority to require corrective action, all grievances related to medical quality of care issues are immediately submitted to the medical director for action. The medical director is required to resolve grievances related to medical quality of care.
e. For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Alliance will include in its written response, the reasons for its determination. The response will clearly state the criteria, clinical guidelines or medical policies used in reaching the determination.

f. The Alliance ensures that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance. Additionally, the decision-maker is a health care professional with clinical expertise in treating a member's condition or disease if any of the following apply:
    i. A grievance with regards to a denial of an expedited resolution of an appeal; and
    ii. Any grievance involving clinical issues.
g. If the Alliance makes an adverse decision, we will notify the member of the decision and 'Your Rights' templates.

6. Appeals of an Adverse Decision

a. Members have the right to appeal an adverse decision, the Alliance notifies the member of the decision and of their right to file an appeal if the Alliance makes an adverse decision as part of resolving the complaint.
b. The Alliance provides a written acknowledgement that is dated and postmarked within five (5) calendar days of receipt.
c. The Alliance provides a written resolution within thirty (30) calendar days of receipt or sooner based on the urgency of the appeal. The resolution contains a clear and concise explanation of the Alliance's decision and 'Your Rights' template.

7. Grievance and Appeals Disclosure

The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."

8. Access to an Independent Medical Review

Included in the resolution to the member with regards to a disposition that denies, modifies, or delays health care services, the Alliance provides the member with a one-page application form and instructions, which the member may return to initiate an independent medical

review. The instructions include the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

For grievances involving a determination that the requested service is not a covered benefit will specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response will either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the member. The resolution will include the notice set forth in §1368.02(b) of the Act in addition to a notice that if the member believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

The Alliance includes on the form any information required by the Department to facilitate the completion of the independent medical review, such as the member's diagnosis or condition, the nature of the disputed health care service sought by the member, a means to identify the member's case, and any other material information.

The form includes the following:

- Notice that a decision not to participate in the independent medical review process may cause the member to forfeit any statutory right to pursue legal action against the Alliance with regards to the disputed health care service.
- A statement indicating the member's consent to obtain any necessary medical records from the Alliance, any of its contracting providers, and any out-of-network provider the member may have consulted on the matter, to be signed by the member.
- Notice of the member's right to provide information or documentation, either directly or through the member's provider, with regards to any of the following:
    - A provider recommendation indicating that the disputed health care service is medically necessary for the member's medical condition;
    - Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the member's medical condition;
    - Reasonable information supporting the member's position that the disputed health care service is or was medically necessary for the member's medical condition, including all information provided to the member by the Alliance or any of its contracting providers, still in the possession of the member, concerning the Alliance's or provider decision with regards to disputing health care service, and a copy of any materials the member submitted to the Alliance, still in possession of the member, in support of the grievance, as well as any additional material that the member believes is relevant.

9. Linguistic and Cultural Needs

The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance

and appeals system through translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

DEFINITIONS / ACRONYMS

1. "Resolved" means that the grievance has reached a final conclusion with respect to the complainant's submitted grievance, and there are no pending member appeals within the Alliance's system, including entities with delegated authority.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Quality Improvement Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description
- MBR-024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance and Appeals Template Acknowledgement Letters
- Grievance and Appeals Template Acknowledgement Letters – Translated Threshold Languages
- Grievance and Appeals Template Resolution Letters
- Grievance and Appeals Template Resolution Letters – Translated Threshold Languages
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

03/01/2018, 04/12/2018, 03/21/2019, 11/21/2020, 11/18/2021, 03/31/2023

REFERENCES

- CA Health and Safety Code section 1368
- CA Health and Safety Code section 1368.01
- CA Health and Safety Code section 1368.02
- CA Health and Safety Code section 1374.30(m)
- 28 CCR §1300.68
- DHCS All Plan Letter 21-011
- DHCS Contract, Exhibit A, Attachment 1(6)(E)
- NCQA ME7: Member Experience

    - Element A: Policies and Procedures for Complaints
    - Element B: Policies and Procedures for Appeals
- Assembly Bill No. 1802
- All Plans Letter 22-018

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Complaints and Resolutions. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-003
Policy Name	Grievance and Appeals Receipt, Review and Resolution
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	08/24/2017
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") shall receive, review and resolve grievances and appeals within the required timeframes set forth by Department of Managed Health Care (Department) state regulations, Department of Health Care Services (DHCS) contractual obligations and National Committee for Quality Assurance (NCQA) accreditation standards.

PROCEDURE

1. Timeframes for Filing

    a. The Alliance will allow the complainant at least 180 calendar days from the date of the incident or action that is the subject of the member's dissatisfaction to file a grievance for our GroupCare members; and
    b. The Alliance will allow the complainant any time to file a grievance about an incident or action that is subject of the member's dissatisfaction for our Medi-Cal members.

2. Grievances that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the standard grievance system (see MBR-024 Exempt Grievances). The Alliance maintains a periodically reviewed log of all exempt grievances which includes:

    - The date of the call,
    - The name of the complainant,

- The complainant's member identification number;
- The nature of the grievance;
- The nature of the resolution; and
- The name of the Alliance representative who took the call and resolved the grievance.

3. Written Record of a Grievance or Appeal

The Alliance creates a written record for each grievance and appeal received; including the date and time received, the name of the member filing, the Alliance representative recording the grievance or appeal, a description of the complaint or problem, a description of the action taken by the Alliance or provider to investigate and resolve, including, but not limited to the member's previous complaint history and follow-up activities associated with the complaint, the proposed resolution by the Alliance or provider, the name of the Alliance provider or staff responsible for resolving, and the date of notification to the member of resolution.

4. Acknowledgment of a Grievance or Appeal

The Alliance provides a written acknowledgement that is dated and postmarked within five (5) calendar days of receipt. A written Acknowledgment to the complainant advises that the grievance has been received, the date of receipt, and provides the name, telephone number and address of the coordinator who was assigned the case and who may be contacted about the grievance.

5. Resolution of a Grievance or Appeal

a. The Alliance investigates the content of the complaint, including all issues relevant to the complaint, and documents all findings as part of the resolution.
b. The Alliance provides a written resolution within thirty (30) calendar days of receipt. The resolution contains a clear and concise explanation of the Alliance's decision.
    i. For those members in a Skilled Nursing Facility, a copy of the notification will also be provided to the Skilled Nursing Facility in which the member resides.
c. In the event a resolution is not reached within 30-calendar days, the Alliance will notify the complainant in writing that the complaint was received, investigated, and of the status of the grievance and provide an estimated completion date of resolution.
d. The Alliance ensures the participation of individuals with authority to require corrective action, all grievances related to medical quality of care issues are immediately submitted to the medical director for action. The medical director is required to resolve grievances related to medical quality of care.
e. For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Alliance will include in its written response, the reasons for its determination. The response will clearly state the criteria, clinical guidelines or medical policies used in reaching the determination.

f. The Alliance ensures that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance. Additionally, the decision-maker is a health care professional with clinical expertise in treating a member's condition or disease if any of the following apply:
    i. A grievance with regards to a denial of an expedited resolution of an appeal; and
    ii. Any grievance involving clinical issues.
g. If the Alliance makes an adverse decision, we will notify the member of the decision and 'Your Rights' templates.

6. Appeals of an Adverse Decision

a. Members have the right to appeal an adverse decision, the Alliance notifies the member of the decision and of their right to file an appeal if the Alliance makes an adverse decision as part of resolving the complaint.
b. The Alliance provides a written acknowledgement that is dated and postmarked within five (5) calendar days of receipt.
c. The Alliance provides a written resolution within thirty (30) calendar days of receipt or sooner based on the urgency of the appeal. The resolution contains a clear and concise explanation of the Alliance's decision and 'Your Rights' template.

7. Grievance and Appeals Disclosure

The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online."

8. Access to an Independent Medical Review

Included in the resolution to the member with regards to a disposition that denies, modifies, or delays health care services, the Alliance provides the member with a one-page application form and instructions, which the member may return to initiate an independent medical

review. The instructions include the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

For grievances involving a determination that the requested service is not a covered benefit will specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response will either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the member. The resolution will include the notice set forth in §1368.02(b) of the Act in addition to a notice that if the member believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

The Alliance includes on the form any information required by the Department to facilitate the completion of the independent medical review, such as the member's diagnosis or condition, the nature of the disputed health care service sought by the member, a means to identify the member's case, and any other material information.

The form includes the following:

- Notice that a decision not to participate in the independent medical review process may cause the member to forfeit any statutory right to pursue legal action against the Alliance with regards to the disputed health care service.
- A statement indicating the member's consent to obtain any necessary medical records from the Alliance, any of its contracting providers, and any out-of-network provider the member may have consulted on the matter, to be signed by the member.
- Notice of the member's right to provide information or documentation, either directly or through the member's provider, with regards to any of the following:
    - A provider recommendation indicating that the disputed health care service is medically necessary for the member's medical condition;
    - Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the member's medical condition;
    - Reasonable information supporting the member's position that the disputed health care service is or was medically necessary for the member's medical condition, including all information provided to the member by the Alliance or any of its contracting providers, still in the possession of the member, concerning the Alliance's or provider decision with regards to disputing health care service, and a copy of any materials the member submitted to the Alliance, still in possession of the member, in support of the grievance, as well as any additional material that the member believes is relevant.

9. Linguistic and Cultural Needs

The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance

and appeals system through translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

DEFINITIONS / ACRONYMS

1. "Resolved" means that the grievance has reached a final conclusion with respect to the complainant's submitted grievance, and there are no pending member appeals within the Alliance's system, including entities with delegated authority.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Quality Improvement Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description
- MBR-024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance and Appeals Template Acknowledgement Letters
- Grievance and Appeals Template Acknowledgement Letters – Translated Threshold Languages
- Grievance and Appeals Template Resolution Letters
- Grievance and Appeals Template Resolution Letters – Translated Threshold Languages
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

03/01/2018, 04/12/2018, 03/21/2019, 11/21/2020, 11/18/2021, 03/31/2023

REFERENCES

- CA Health and Safety Code section 1368
- CA Health and Safety Code section 1368.01
- CA Health and Safety Code section 1368.02
- CA Health and Safety Code section 1374.30(m)
- 28 CCR §1300.68
- DHCS All Plan Letter 21-011
- DHCS Contract, Exhibit A, Attachment 1(6)(E)
- NCQA ME7: Member Experience

    - Element A: Policies and Procedures for Complaints
    - Element B: Policies and Procedures for Appeals
- Assembly Bill No. 1802
- All Plans Letter 22-018

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Complaints and Resolutions. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-004
Policy Name	Member Education/Notification Requirements
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	11/18/2021
Approval/Revision Date	~~10/19/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") will inform its members upon enrollment in the Alliance and annually thereafter of the procedures for processing and resolving grievances and appeals. The information includes the location and toll-free telephone number where grievance or appeals may be submitted.

PROCEDURE

1. Notification of the Grievance and Appeals System

    a. The Alliance notifies members through the Evidence of Coverage (EOC) of the Grievance and Appeals System and includes information on the Alliance's procedures for filing and resolving Grievances and Appeals, the toll-free telephone number and our local telephone number, and the address for mailing Grievances and Appeals. The notice also includes information with regards to the DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.

    b. The Alliance's grievance system allows the member to file grievances for at least 180 calendar days following any incident or action that is subject of the member's dissatisfaction.

2. Obtaining Grievance and Appeals Forms

The Alliance notifies members through the EOC of the process for obtaining Grievance and Appeals forms. A description of the procedure for filing Grievances and Appeals are readily available at each facility of the Alliance, on the Alliance's website, and at each contracting provider's office or facility. The Alliance ensures that assistance in filing Grievances and Appeals is provided at each location where Grievances and Appeals are submitted. Grievance and Appeals forms are also promptly provided upon request.

3. Opportunity to Seek an Independent Medical Review (IMR)

   a. The Alliance provides our members with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. Members may designate an agent to act on his or her behalf and the provider may join with or otherwise assist the member in seeking an independent medical review and may advocate on behalf of the member.

   b. Information concerning the right of a member to request an independent medical review in cases where the member believes that the health care services have been improperly denied, modified, or delayed by the Alliance, or by our delegated networks is prominently displayed in the Evidence of Coverage, Alliance contracts, on member Evidence of Coverage forms, on copies of Alliance procedures for resolving grievances, on letter of denials (NOA) issued by the Alliance or our contracting organizations, on the grievance forms, and on all written responses to grievances.

4. Grievance Disclosure

The Alliance publishes the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the Alliance's telephone number, and the Department's Internet address, on every contract, on every evidence of coverage, on copies of Alliance grievance and appeals procedures, on grievance and appeals forms, and on all written notices to members required under the grievance and appeals process, including any written communications to a member that offers the member the opportunity to participate in the grievance or appeal process and on all written responses to grievance and appeals.

The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- GroupCare Evidence of Coverage
- Medi-Cal Evidence of Coverage
- Members Rights
- Grievance Form
- Notice of Action Templates

REVISION HISTORY

11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368(a)(2)
- CA Health and Safety Code section 1368.02(b)
- CA Health and Safety Code section 1374.30(e)(i)
- 28 CCR 1300.68(b)(2) and (9)
- Assembly Bill No. 1802

MONITORING

The Alliance reviews member facing material on an annual basis to ensure that they include all regulatory requirements.

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POLICY AND PROCEDURE

Policy Number	G&A-004
Policy Name	Member Education/Notification Requirements
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	11/18/2021
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") will inform its members upon enrollment in the Alliance and annually thereafter of the procedures for processing and resolving grievances and appeals. The information includes the location and toll-free telephone number where grievance or appeals may be submitted.

PROCEDURE

1. Notification of the Grievance and Appeals System

    a. The Alliance notifies members through the Evidence of Coverage (EOC) of the Grievance and Appeals System and includes information on the Alliance's procedures for filing and resolving Grievances and Appeals, the toll-free telephone number and our local telephone number, and the address for mailing Grievances and Appeals. The notice also includes information with regards to the DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.

    b. The Alliance's grievance system allows the member to file grievances for at least 180 calendar days following any incident or action that is subject of the member's dissatisfaction.

2. Obtaining Grievance and Appeals Forms

The Alliance notifies members through the EOC of the process for obtaining Grievance and Appeals forms. A description of the procedure for filing Grievances and Appeals are readily available at each facility of the Alliance, on the Alliance's website, and at each contracting provider's office or facility. The Alliance ensures that assistance in filing Grievances and Appeals is provided at each location where Grievances and Appeals are submitted. Grievance and Appeals forms are also promptly provided upon request.

3. Opportunity to Seek an Independent Medical Review (IMR)

   a. The Alliance provides our members with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. Members may designate an agent to act on his or her behalf and the provider may join with or otherwise assist the member in seeking an independent medical review and may advocate on behalf of the member.

   b. Information concerning the right of a member to request an independent medical review in cases where the member believes that the health care services have been improperly denied, modified, or delayed by the Alliance, or by our delegated networks is prominently displayed in the Evidence of Coverage, Alliance contracts, on member Evidence of Coverage forms, on copies of Alliance procedures for resolving grievances, on letter of denials (NOA) issued by the Alliance or our contracting organizations, on the grievance forms, and on all written responses to grievances.

4. Grievance Disclosure

The Alliance publishes the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the Alliance's telephone number, and the Department's Internet address, on every contract, on every evidence of coverage, on copies of Alliance grievance and appeals procedures, on grievance and appeals forms, and on all written notices to members required under the grievance and appeals process, including any written communications to a member that offers the member the opportunity to participate in the grievance or appeal process and on all written responses to grievance and appeals.

The disclosure includes a current hyperlink to the Department of Managed Health Care internet website, and includes a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- GroupCare Evidence of Coverage
- Medi-Cal Evidence of Coverage
- Members Rights
- Grievance Form
- Notice of Action Templates

REVISION HISTORY

11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368(a)(2)
- CA Health and Safety Code section 1368.02(b)
- CA Health and Safety Code section 1374.30(e)(i)
- 28 CCR 1300.68(b)(2) and (9)
- Assembly Bill No. 1802

MONITORING

The Alliance reviews member facing material on an annual basis to ensure that they include all regulatory requirements.

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POLICY AND PROCEDURE

Policy Number	G&A-005
Policy Name	Expedited Review of Urgent Grievance and Appeals
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	04/12/2018
Approval/Revision Date	~~10/19/2023~~11/15/2024

POLICY STATEMENT

The Alliance ensures that grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function are reviewed expeditiously and resolved within 72 hours or sooner if the medical condition requires.

PROCEDURE

1. Expedited Review of Urgent Grievance and Appeals

   The Alliance provides expedited review of grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function.

   a. When a case requiring expedited review, the Alliance immediately informs the member of their right to notify the Department of the grievance or appeal.
   b. There is no requirement that the member has to participate in the Alliance's grievance and appeals process prior to applying to the Department for review of the expedited grievance or appeal.
   c. The Alliance provides consideration of the member's medical condition when determining the response time.

2. Resolution of Urgent Grievance and Appeals

   a. The Alliance makes a reasonable effort to provide oral notice of resolution to the member.

b. A written statement on the disposition or pending status of the grievance or appeal is provided to the member and the Department no later than 72 hours from receipt of the grievance or appeal, the Alliance records the time and date of the expedited grievance or appeal receipt which drives the timeframe for resolution.
c. The written response will contain a clear and concise explanation of the Alliance's decision.
d. For grievance or appeals involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Alliance will include in its written response, the reasons for its determination. The response will clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The written response will advise the member that the determination may be considered by the Department's Independent medical review system.
e. For grievance and appeals involving a determination that the requested service is not a covered benefit, the Alliance will specify in the evidence of coverage that excludes the service. The response will either identify the document and page where the provision is found, direct the complainant to the applicable section of the EOC containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the member. In addition to the below grievance and appeal disclosure, the response will also include a notice that if the member believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

3. Grievance and Appeal Disclosure

The Department's telephone number, the California Relay Service's telephone numbers, the Alliance's telephone number and the Department's internet address are displayed in the evidence of coverage, on grievance forms, and on acknowledgements and responses to grievances in 12-point boldface type with the following statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

4. DMHC Health Plan Contacts for Urgent Grievance and Appeals

The Alliance allows the Department to contact the Alliance with regards to urgent grievance and appeals 24 hours a day, 7 days a week. During normal work hours, the Alliance responds to the Department within 30 minutes after initial contact from the Department. During non-work hours, the Alliance responds to the Department within 1 hour after initial contact from the Department.

a. The Alliance has a plan representative with authority on the Alliance's behalf available to resolve urgent grievance and appeals and authorize the provision of health care services covered under the member's plan contract in a medically appropriate and timely manner. The authority includes making financial decisions for expenditure of funds on behalf of the Alliance without first having to obtain approval from supervisors or other superiors with the Alliance. The representative may consult with other Alliance staff on urgent grievance and appeals.
b. The Alliance provides the Department with the following information with regards to urgent grievance and appeals:
    i. A description of the system established by the Alliance to resolve urgent grievance and appeals. The description includes the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts with regards to urgent grievance and appeals, Provisions for scheduling include the names and titles of the plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.
    ii. A description of how the Department can access the grievance and appeal system established by the Alliance.
    iii. The Alliance notifies the Department at least 30 days in advance of implementing any revisions to the system established by the Alliance.

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

- Complaints and Resolutions Department
- Utilization Management Department
- Quality Improvement Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DMHC Health Plan Complaint Contacts

- Expedited Appeal Check List
- Expedited Grievance Check List
- Expedited Grievance and Appeals Template Letters
- Expedited Grievance and Appeals Template Letters – Translated Threshold

REVISION HISTORY

04/12/2018, 03/21/2019, 5/21/2020, 03/18/2021, 11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368.01(a)(b)
- CA Health and Safety Code section 1368.02(b)
- 28 CCR 1300.68.01(a)(b)
- 28 CCR 1300.68(d)(3),(4) and (5)

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	G&A-005
Policy Name	Expedited Review of Urgent Grievance and Appeals
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	04/12/2018
Approval/Revision Date	11/15/2024

POLICY STATEMENT

The Alliance ensures that grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function are reviewed expeditiously and resolved within 72 hours or sooner if the medical condition requires.

PROCEDURE

1. Expedited Review of Urgent Grievance and Appeals

   The Alliance provides expedited review of grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function.

   a. When a case requiring expedited review, the Alliance immediately informs the member of their right to notify the Department of the grievance or appeal.
   b. There is no requirement that the member has to participate in the Alliance's grievance and appeals process prior to applying to the Department for review of the expedited grievance or appeal.
   c. The Alliance provides consideration of the member's medical condition when determining the response time.

2. Resolution of Urgent Grievance and Appeals

   a. The Alliance makes a reasonable effort to provide oral notice of resolution to the member.

b. A written statement on the disposition or pending status of the grievance or appeal is provided to the member and the Department no later than 72 hours from receipt of the grievance or appeal, the Alliance records the time and date of the expedited grievance or appeal receipt which drives the timeframe for resolution.
c. The written response will contain a clear and concise explanation of the Alliance's decision.
d. For grievance or appeals involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Alliance will include in its written response, the reasons for its determination. The response will clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The written response will advise the member that the determination may be considered by the Department's Independent medical review system.
e. For grievance and appeals involving a determination that the requested service is not a covered benefit, the Alliance will specify in the evidence of coverage that excludes the service. The response will either identify the document and page where the provision is found, direct the complainant to the applicable section of the EOC containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the member. In addition to the below grievance and appeal disclosure, the response will also include a notice that if the member believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.

3. Grievance and Appeal Disclosure

The Department's telephone number, the California Relay Service's telephone numbers, the Alliance's telephone number and the Department's internet address are displayed in the evidence of coverage, on grievance forms, and on acknowledgements and responses to grievances in 12-point boldface type with the following statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

4. DMHC Health Plan Contacts for Urgent Grievance and Appeals

The Alliance allows the Department to contact the Alliance with regards to urgent grievance and appeals 24 hours a day, 7 days a week. During normal work hours, the Alliance responds to the Department within 30 minutes after initial contact from the Department. During non-work hours, the Alliance responds to the Department within 1 hour after initial contact from the Department.

a. The Alliance has a plan representative with authority on the Alliance's behalf available to resolve urgent grievance and appeals and authorize the provision of health care services covered under the member's plan contract in a medically appropriate and timely manner. The authority includes making financial decisions for expenditure of funds on behalf of the Alliance without first having to obtain approval from supervisors or other superiors with the Alliance. The representative may consult with other Alliance staff on urgent grievance and appeals.
b. The Alliance provides the Department with the following information with regards to urgent grievance and appeals:
    i. A description of the system established by the Alliance to resolve urgent grievance and appeals. The description includes the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts with regards to urgent grievance and appeals, Provisions for scheduling include the names and titles of the plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.
    ii. A description of how the Department can access the grievance and appeal system established by the Alliance.
    iii. The Alliance notifies the Department at least 30 days in advance of implementing any revisions to the system established by the Alliance.

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

- Complaints and Resolutions Department
- Utilization Management Department
- Quality Improvement Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DMHC Health Plan Complaint Contacts

- Expedited Appeal Check List
- Expedited Grievance Check List
- Expedited Grievance and Appeals Template Letters
- Expedited Grievance and Appeals Template Letters – Translated Threshold

REVISION HISTORY

04/12/2018, 03/21/2019, 5/21/2020, 03/18/2021, 11/18/2021, 03/31/2023, 10/19/2023

REFERENCES

- CA Health and Safety Code section 1368.01(a)(b)
- CA Health and Safety Code section 1368.02(b)
- 28 CCR 1300.68.01(a)(b)
- 28 CCR 1300.68(d)(3),(4) and (5)

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	G&A-006
Policy Name	Independent Medical Review (IMR)
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	04/12/2018
Approval/Revision Date	~~03/31/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health's ("Alliance") provides a member with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the Alliance, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary. A member may designate an agent to act on their behalf. The provider may join with or otherwise assist the member in seeking an IMR, and may advocate on behalf of the member.

PROCEDURE

1. Notification of Requesting an Independent Medical Review

    a. For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, or the denial of coverage for experimental or investigational therapy, or denial of urgent or emergency services, or deny reimbursement for urgent or emergency services, the Alliance will clearly state reason for its determination; the criteria, clinical guidelines or medical policies used in reaching the determination.
    b. The response will also advise the member that the determination may be considered by the Department's independent medical review system.
    c. The response will include an application (DMHC IMR Form) for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

d. The Alliance publishes on every contract, on every evidence of coverage, on copies of Alliance grievance and appeals procedures, on grievance and appeals forms, and on all written notices to members required under the grievance and appeals process, including any written communications to a member informing the right of a member to request an independent medical review in cases when the member believes that health care services have been improperly denied, modified, or delayed by the Alliance, or one of our contracted providers.

2. Requesting an Independent Medical Review
    a. A member may apply to the department for an independent medical within six (6) months of any of the qualifying periods or following conditions listed under this section, the director may extend the application deadline beyond six (6) months if the circumstances of a case warrant the extension;
    b. A member may apply to the department for an independent medical review when all of the following conditions are met:
        i. One of the following:
            1. The member's provider has recommended a health care service as medically necessary, or
            2. The member has received urgent care or emergency services that a provider determined was medically necessary, or
            3. The member, in the absence of a provider recommendation that a health care service is medically necessary or the receipt of urgent care or emergency services by a provider that a provider determined was medically necessary, has been seen by a contracted provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.
        ii. The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.
        iii. When the member has filed a grievance with the Alliance or our contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 30 days, the member will not be required to participate in the Alliance's grievance process for more than 30 days; and
        iv. When the member has filed an expedited grievance with the Alliance or our contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 72 hours, the member will not be required to participate in the Alliance's expedited grievance process for more than 72 hours.
    c. The member will not be responsible for payment of application or processing fees of any kind.
    d. In any case in which the member or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review or pursuant to subdivision (b) of Section 1368. In addition, the department will be the final arbiter when there is a question as to whether the member grievance is a disputed health care service or a coverage

decision, if the grievance appears to include any medical necessity issue, the grievance will be resolved pursuant to an independent medical review in accordance to this policy and procedure; and whether extraordinary and compelling circumstances exist that waive the requirement that the member first participate in the Alliance's grievance system.

3. Responding to a Request for an Independent Medical Review

    a. Upon notice from the department that the member has applied for an IMR, the Alliance or its contracting providers will provide to the IMR organization designated by the department a copy of all of the following documents within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review of the Alliance's receipt of the department's notice of a request by a member for an IMR:
        i. A complete and legible copy of all medical records in the possession of the Alliance or its contracting providers used by the Alliance in making its decision and relevant to each of the following:
            1. The member's medical condition;
            2. The health care services being provided by the Alliance and its contracting providers for the condition; and
            3. The disputed health care services requested by the member for the condition.
        ii. Any newly developed or discovered relevant medical records in the possession of the Alliance or its contracting providers after the initial documents are provided to the IMR organization will be forwarded immediately to the IMR organization, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases. The Alliance will concurrently provide a copy of medical records to the member or the member's provider, if authorized by the member, unless the offer of medical records is declined or otherwise prohibited by law;
        iii. A copy of all information provided to the member by the Alliance and any of its contracting providers concerning the Alliance's and provider decisions with regards to the member's condition and care, and a copy of any materials the member or the member's provider submitted to the Alliance and to the Alliance's contracting providers in support of the member's request for disputed health care services. This will include the written response to the member's grievance;
        iv. A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the Alliance's resolution of the member's grievance;
        v. The Alliance's response to any additional issues raised in the member's application for the IMR; and
        vi. A copy of any other relevant documents or information used by the Alliance or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the Alliance and its contracting providers explaining the reasons for the

decision to deny, modify, or delay disputed health care services on the basis of medical necessity.

b. Additional medical records or other information requested by the IMR organization will be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. For expedited reviews, the Alliance will immediately notify the member and the member's provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the Alliance or its contracting providers.

c. The Alliance will promptly issue a notification to the member, after submitting all of the required material to the IMR organization that includes an annotated list of documents submitted and will offer the member the opportunity to request copies of those documents from the Alliance.

4. Experimental or Investigational Therapies

a. The Alliance will provide an external, independent review process to examine the Alliance's coverage decisions with regards to experimental or investigational therapies for members who have a life-threatening or seriously debilitating condition.

b. Included with the member's application to the Department for independent medical review will be a copy of the Alliance or contracted provider's written denial of the therapy or medical service based on the determination that the therapy or service is experimental or investigational.

c. A certification from the member's treating physician will be included with the application for independent medical review. The physician's certification will be on a form the Department entitled, "Physician Certification Experimental/Investigational Denials", or contain all of the following information:

i. The member has a condition as defined in H&S §1370.4(a)(1)

ii. Background information including the name of the member and the Alliance; the physician's name, specialty, board certification, address, telephone, and fax number; whether the physician is contracted with the Alliance; the member's medical condition; and the specific drug, device, procedure, or other therapy recommended or requested for the member's medical condition.

iii. For non-contracting physicians, the certification will also include the following:

1. The physician's license, board-certification or board eligibility to practice in the area appropriate to treat the member's condition; and

2. Reference to, or copies of, two documents from the medical or scientific literature, specified in §1370.4(d)

iv. The following statement and physician's signature: "I certify that the requested therapy is likely to be more beneficial than any standard therapy. The information provided herein is true and correct;"

v. Where expedited review is requested the certification shall include a statement that imminent and serious threat to the health of the member exists pursuant to Health and Safety Code Section 1374.31, or the proposed therapy would be significantly less effective if not promptly initiated; and

vi. Attachments, including any additional references or copies of medical and/or scientific literature considered relevant to the requested therapy and any other information relevant to the request.

5. Expeditious Review: Imminent Threat to Health

   a. If there is an imminent and serious threat to the health of the member, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the member, all necessary information and documents will be delivered to an independent medical review organization within 24 hours of approval of the request for review.

6. Implementing IMR Decision & Reimbursement

   a. The Alliance will promptly implement the decision upon receiving the decision adopted by the director pursuant to §1374.33 that the disputed health care service is medically necessary.
      i. In the case of reimbursement for services already rendered, the Alliance will reimburse the provider or member, whichever applies, within five (5) working days.
      ii. In the case of services not yet rendered, the Alliance will authorize the services within five (5) working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the member's medical condition, and will inform the member and the provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of §1367.01.
   b. The Alliance will not engage in any conduct that has the effect of prolonging the IMR process.
   c. The Alliance will promptly reimburse the member for any reasonable costs associated with services if the disputed health care services were found to be a covered benefit under the terms and conditions of the Alliance contract, and the services were found to have been medically necessary by the IMR organization, and either the member's decision to secure the services outside of the Alliance network was reasonable under the emergency or urgent medical circumstances,

or the Alliance contract does not require or provide prior authorization for the services provided to the member.

DEFINITIONS / ACRONYMS

1. "Disputed health care service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.
2. "Coverage decision" means the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.
3. "Life-threatening" means wither or both of the following:
    a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
    b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
4. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Compliance Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DMHC IMR Form
- DMHC IMR Request Check List
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

04/12/18, 05/19/2019, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023

REFERENCES

- CA Health and Safety Code §1367.01(h)(3)

- CA Health and Safety Code §1374.30
- CA Health and Safety Code §1374.31
- CA Health and Safety Code §1374.34
- 28 CCR §1300.68(d)(4)
- 28 CCR §1300.70.4(a)
- 28 CCR §1300.74.30

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-006
Policy Name	Independent Medical Review (IMR)
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	04/12/2018
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health's ("Alliance") provides a member with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the Alliance, or by one of its contracting providers, if the decision was based in whole or in part, on a finding that the proposed health care services are not medically necessary. A member may designate an agent to act on their behalf. The provider may join with or otherwise assist the member in seeking an IMR, and may advocate on behalf of the member.

PROCEDURE

1. Notification of Requesting an Independent Medical Review

    a. For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, or the denial of coverage for experimental or investigational therapy, or denial of urgent or emergency services, or deny reimbursement for urgent or emergency services, the Alliance will clearly state reason for its determination; the criteria, clinical guidelines or medical policies used in reaching the determination.
    b. The response will also advise the member that the determination may be considered by the Department's independent medical review system.
    c. The response will include an application (DMHC IMR Form) for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

d. The Alliance publishes on every contract, on every evidence of coverage, on copies of Alliance grievance and appeals procedures, on grievance and appeals forms, and on all written notices to members required under the grievance and appeals process, including any written communications to a member informing the right of a member to request an independent medical review in cases when the member believes that health care services have been improperly denied, modified, or delayed by the Alliance, or one of our contracted providers.

2. Requesting an Independent Medical Review
    a. A member may apply to the department for an independent medical within six (6) months of any of the qualifying periods or following conditions listed under this section, the director may extend the application deadline beyond six (6) months if the circumstances of a case warrant the extension;
    b. A member may apply to the department for an independent medical review when all of the following conditions are met:
        i. One of the following:
            1. The member's provider has recommended a health care service as medically necessary, or
            2. The member has received urgent care or emergency services that a provider determined was medically necessary, or
            3. The member, in the absence of a provider recommendation that a health care service is medically necessary or the receipt of urgent care or emergency services by a provider that a provider determined was medically necessary, has been seen by a contracted provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.
        ii. The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.
        iii. When the member has filed a grievance with the Alliance or our contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 30 days, the member will not be required to participate in the Alliance's grievance process for more than 30 days; and
        iv. When the member has filed an expedited grievance with the Alliance or our contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 72 hours, the member will not be required to participate in the Alliance's expedited grievance process for more than 72 hours.
    c. The member will not be responsible for payment of application or processing fees of any kind.
    d. In any case in which the member or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review or pursuant to subdivision (b) of Section 1368. In addition, the department will be the final arbiter when there is a question as to whether the member grievance is a disputed health care service or a coverage

decision, if the grievance appears to include any medical necessity issue, the grievance will be resolved pursuant to an independent medical review in accordance to this policy and procedure; and whether extraordinary and compelling circumstances exist that waive the requirement that the member first participate in the Alliance's grievance system.

3. Responding to a Request for an Independent Medical Review

    a. Upon notice from the department that the member has applied for an IMR, the Alliance or its contracting providers will provide to the IMR organization designated by the department a copy of all of the following documents within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review of the Alliance's receipt of the department's notice of a request by a member for an IMR:
        i. A complete and legible copy of all medical records in the possession of the Alliance or its contracting providers used by the Alliance in making its decision and relevant to each of the following:
            1. The member's medical condition;
            2. The health care services being provided by the Alliance and its contracting providers for the condition; and
            3. The disputed health care services requested by the member for the condition.
        ii. Any newly developed or discovered relevant medical records in the possession of the Alliance or its contracting providers after the initial documents are provided to the IMR organization will be forwarded immediately to the IMR organization, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases. The Alliance will concurrently provide a copy of medical records to the member or the member's provider, if authorized by the member, unless the offer of medical records is declined or otherwise prohibited by law;
        iii. A copy of all information provided to the member by the Alliance and any of its contracting providers concerning the Alliance's and provider decisions with regards to the member's condition and care, and a copy of any materials the member or the member's provider submitted to the Alliance and to the Alliance's contracting providers in support of the member's request for disputed health care services. This will include the written response to the member's grievance;
        iv. A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the Alliance's resolution of the member's grievance;
        v. The Alliance's response to any additional issues raised in the member's application for the IMR; and
        vi. A copy of any other relevant documents or information used by the Alliance or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the Alliance and its contracting providers explaining the reasons for the

decision to deny, modify, or delay disputed health care services on the basis of medical necessity.

b. Additional medical records or other information requested by the IMR organization will be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. For expedited reviews, the Alliance will immediately notify the member and the member's provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the Alliance or its contracting providers.

c. The Alliance will promptly issue a notification to the member, after submitting all of the required material to the IMR organization that includes an annotated list of documents submitted and will offer the member the opportunity to request copies of those documents from the Alliance.

4. Experimental or Investigational Therapies

a. The Alliance will provide an external, independent review process to examine the Alliance's coverage decisions with regards to experimental or investigational therapies for members who have a life-threatening or seriously debilitating condition.

b. Included with the member's application to the Department for independent medical review will be a copy of the Alliance or contracted provider's written denial of the therapy or medical service based on the determination that the therapy or service is experimental or investigational.

c. A certification from the member's treating physician will be included with the application for independent medical review. The physician's certification will be on a form the Department entitled, "Physician Certification Experimental/Investigational Denials", or contain all of the following information:

i. The member has a condition as defined in H&S §1370.4(a)(1)

ii. Background information including the name of the member and the Alliance; the physician's name, specialty, board certification, address, telephone, and fax number; whether the physician is contracted with the Alliance; the member's medical condition; and the specific drug, device, procedure, or other therapy recommended or requested for the member's medical condition.

iii. For non-contracting physicians, the certification will also include the following:

1. The physician's license, board-certification or board eligibility to practice in the area appropriate to treat the member's condition; and

2. Reference to, or copies of, two documents from the medical or scientific literature, specified in §1370.4(d)

iv. The following statement and physician's signature: "I certify that the requested therapy is likely to be more beneficial than any standard therapy. The information provided herein is true and correct;"

v. Where expedited review is requested the certification shall include a statement that imminent and serious threat to the health of the member exists pursuant to Health and Safety Code Section 1374.31, or the proposed therapy would be significantly less effective if not promptly initiated; and

vi. Attachments, including any additional references or copies of medical and/or scientific literature considered relevant to the requested therapy and any other information relevant to the request.

5. Expeditious Review: Imminent Threat to Health

   a. If there is an imminent and serious threat to the health of the member, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the member, all necessary information and documents will be delivered to an independent medical review organization within 24 hours of approval of the request for review.

6. Implementing IMR Decision & Reimbursement

   a. The Alliance will promptly implement the decision upon receiving the decision adopted by the director pursuant to §1374.33 that the disputed health care service is medically necessary.
      i. In the case of reimbursement for services already rendered, the Alliance will reimburse the provider or member, whichever applies, within five (5) working days.
      ii. In the case of services not yet rendered, the Alliance will authorize the services within five (5) working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the member's medical condition, and will inform the member and the provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of §1367.01.
   b. The Alliance will not engage in any conduct that has the effect of prolonging the IMR process.
   c. The Alliance will promptly reimburse the member for any reasonable costs associated with services if the disputed health care services were found to be a covered benefit under the terms and conditions of the Alliance contract, and the services were found to have been medically necessary by the IMR organization, and either the member's decision to secure the services outside of the Alliance network was reasonable under the emergency or urgent medical circumstances,

or the Alliance contract does not require or provide prior authorization for the services provided to the member.

DEFINITIONS / ACRONYMS

1. "Disputed health care service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.
2. "Coverage decision" means the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.
3. “Life-threatening” means wither or both of the following:
    a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
    b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
4. “Seriously debilitating” means diseases or conditions that cause major irreversible morbidity.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Compliance Department

RELATED POLICIES AND PROCEDURES

- G&A-001 Grievance and Appeals System Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DMHC IMR Form
- DMHC IMR Request Check List
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

04/12/18, 05/19/2019, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023

REFERENCES

- CA Health and Safety Code §1367.01(h)(3)

- CA Health and Safety Code §1374.30
- CA Health and Safety Code §1374.31
- CA Health and Safety Code §1374.34
- 28 CCR §1300.68(d)(4)
- 28 CCR §1300.70.4(a)
- 28 CCR §1300.74.30

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	G&A-007
Policy Name	State Fair Hearings
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal
Effective Date	08/24/2017
Approval/Revision Date	~~03/31/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") will maintain a process for notifying members of their right to request a State Fair Hearing when issuing a Notice of Appeal Resolution ("NAR") indicating that an Adverse Benefit Determination is upheld.

PROCEDURE

Members have the right to request a State Fair Hearing when a claim for medical assistance is denied. Prior to requesting a State Fair Hearing, members must use all recourse available within the Alliance's appeal process. If the Alliance does not act upon the appeal within the required timelines, the appeal process is deemed exhausted, and the member may go directly to State Fair Hearing. The Alliance notifies its members of its final decision to uphold an Adverse Benefit Determination by issuing a NAR and enclosing the member's rights to request a State Fair Hearing, including any applicable forms.

Notice of member rights to a State Fair Hearing includes instructions on how the member may request a State Fair Hearing and the following:

A. Timeframe for requesting a State Fair Hearing.
   1. A member must request a State Fair Hearing within one-hundred twenty (120) calendar days from the date of the NAR or if the Alliance fails to adhere to timeframes for resolving an Appeal as outlined in policies G&A-003 Grievance Receipt, Review and Resolution G&A-008 Adverse Benefit Determination Appeals Process, as appropriate.

   2. If member is currently receiving treatment and wants to continue receiving treatment, member must request a State Fair Hearing within ten (10) days from receipt of NAR or date the letter is postmarked, or before the date services are scheduled to stop.

B. State Fair Hearing Timeframes.

1. **Standard Hearing Resolution**: the Alliance notifies members that the State must reach its decision within ninety (90) calendar days of the date of the request.

2. **Expedited Hearing Resolution**: the Alliance notifies members that the State must reach its decision within three (3) working days of the day of the request.

3. **Overturned Decisions**: When a decision is overturned by the state, the Alliance authorizes or provides the disputed services promptly and as expeditiously as the member's condition requires, but no later than the seventy-two (72) hours from the date the Alliance receives notice reversing the determination.

The Alliance cooperates with the member and the Office of Administrative Hearings and Appeals ("OAHA") and provides information, as necessary, to support its Appeal determination.

DEFINITIONS / ACRONYMS

Appeal is defined as a review by AAH of an Adverse Benefit Determination, including review of Grievances that involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested services was not a covered benefit, as applicable per State regulations.

Adverse Benefit Determination is defined to mean any of the following actions taken by AAH:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident in a rural area with only one managed care plan, the denial of the beneficiary's request to obtain services outside of the network.
7. The denial of a beneficiary's request to dispute financial liability.

Notice of Appeal Resolution (NAR) is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

State Fair Hearing is an external appeal process designed to be a fair and impartial appeal process for providers and individuals who are dissatisfied with actions taken by AAH. The State Fair Hearing is administered by the OAHA – established by and working independently of the Department of Managed Health Care.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department

RELATED POLICIES AND PROCEDURES

- G&A-003 Grievance and Appeals Receipt, Review and Resolution
- G&A-008 Adverse Benefit Determination Appeals Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- State Fair Hearing Workflow
- "Your Rights"

REVISION HISTORY

08/24/2017, 03/21/2019, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023

REFERENCES

- DHCS All Plan Letter 21-011
- Title 22, CCR § 5104.2
- Title 42, CFR § 438.408(f)(1) and (2)
- Title 42, CFR § 431.244(f)(1) and (2)
- Title 42, CFR § 438.424(a)

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Grievance and Appeals. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-007
Policy Name	State Fair Hearings
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal
Effective Date	08/24/2017
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") will maintain a process for notifying members of their right to request a State Fair Hearing when issuing a Notice of Appeal Resolution ("NAR") indicating that an Adverse Benefit Determination is upheld.

PROCEDURE

Members have the right to request a State Fair Hearing when a claim for medical assistance is denied. Prior to requesting a State Fair Hearing, members must use all recourse available within the Alliance's appeal process. If the Alliance does not act upon the appeal within the required timelines, the appeal process is deemed exhausted, and the member may go directly to State Fair Hearing. The Alliance notifies its members of its final decision to uphold an Adverse Benefit Determination by issuing a NAR and enclosing the member's rights to request a State Fair Hearing, including any applicable forms.

Notice of member rights to a State Fair Hearing includes instructions on how the member may request a State Fair Hearing and the following:

A. Timeframe for requesting a State Fair Hearing.
   1. A member must request a State Fair Hearing within one-hundred twenty (120) calendar days from the date of the NAR or if the Alliance fails to adhere to timeframes for resolving an Appeal as outlined in policies G&A-003 Grievance Receipt, Review and Resolution G&A-008 Adverse Benefit Determination Appeals Process, as appropriate.

   2. If member is currently receiving treatment and wants to continue receiving treatment, member must request a State Fair Hearing within ten (10) days from receipt of NAR or date the letter is postmarked, or before the date services are scheduled to stop.

B. State Fair Hearing Timeframes.

1. **Standard Hearing Resolution**: the Alliance notifies members that the State must reach its decision within ninety (90) calendar days of the date of the request.

2. **Expedited Hearing Resolution**: the Alliance notifies members that the State must reach its decision within three (3) working days of the day of the request.

3. **Overturned Decisions**: When a decision is overturned by the state, the Alliance authorizes or provides the disputed services promptly and as expeditiously as the member's condition requires, but no later than the seventy-two (72) hours from the date the Alliance receives notice reversing the determination.

The Alliance cooperates with the member and the Office of Administrative Hearings and Appeals ("OAHA") and provides information, as necessary, to support its Appeal determination.

DEFINITIONS / ACRONYMS

Appeal is defined as a review by AAH of an Adverse Benefit Determination, including review of Grievances that involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested services was not a covered benefit, as applicable per State regulations.

Adverse Benefit Determination is defined to mean any of the following actions taken by AAH:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident in a rural area with only one managed care plan, the denial of the beneficiary's request to obtain services outside of the network.
7. The denial of a beneficiary's request to dispute financial liability.

Notice of Appeal Resolution (NAR) is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

State Fair Hearing is an external appeal process designed to be a fair and impartial appeal process for providers and individuals who are dissatisfied with actions taken by AAH. The State Fair Hearing is administered by the OAHA – established by and working independently of the Department of Managed Health Care.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department

RELATED POLICIES AND PROCEDURES

- G&A-003 Grievance and Appeals Receipt, Review and Resolution
- G&A-008 Adverse Benefit Determination Appeals Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- State Fair Hearing Workflow
- "Your Rights"

REVISION HISTORY

08/24/2017, 03/21/2019, 05/21/2020, 03/18/2021, 11/18/2021, 03/31/2023

REFERENCES

- DHCS All Plan Letter 21-011
- Title 22, CCR § 5104.2
- Title 42, CFR § 438.408(f)(1) and (2)
- Title 42, CFR § 431.244(f)(1) and (2)
- Title 42, CFR § 438.424(a)

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
d. Responses on the findings are sent to Compliance 30 days after the request;
e. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Grievance and Appeals. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-008
Policy Name	Adverse Benefit Determination Appeals Process
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	12/17/2015
Approval/Revision Date	~~03/31/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("AAH") will maintain an established, impartial process for resolving members' appeals of an Adverse Benefit Determinations based on medical necessity and benefit determinations with regards to their care and service. Members may have only one level of appeal before they have exhausted their appeal rights with the Plan.

PROCEDURE

Alameda Alliance for Health ("AAH") has established and annually reviews and updates written policies and procedures for the submittal, processing and resolution of Utilization Management (UM) appeals. The policies and procedures apply to medical necessity and benefit appeal processing.

1. AAH provides a Notice of Action (NOA) that informs members and providers that a medical service has been denied, deferred, or modified. The notice also includes the timely filing requirements if the member chooses to appeal the determination.

   - AAH will allow at least 180 calendar days from the date of the NOA for our GroupCare member or member's representative to appeal the determination; and
   - AAH will allow at least 60 calendar days from the date of the NOA for our Medi-Cal member or member's representative to appeal the determination.

   If the case does not meet timely filing for either GroupCare or Medi-Cal, the case will be logged and closed as a grievance~~upheld based on timely filing~~. The resolution will include the member's rights to appeal the determination.

2. AAH documents the substance of an appeal and actions taken including, but not limited to:

    - The member's reason for appealing the previous decision;
    - Additional clinical or other information provided with the appeal request;
    - Previous denial or appeal history; and
    - Follow-up activities associated with the denial and conducted before the current appeal.

3. AAH thoroughly investigates all appeals received, including the aspects of clinical care or condition involved, and document in the electronic system. Investigation may include a review of actions taken by AAH or the provider, obtaining relevant medical records, and/or review of clinical guidelines, criteria and protocols relevant to the substance of the appeal. Investigation shall include any written comment, documents or other information submitted by the Member or Member's representative.

4. AAH allows the member or member's designated representative the opportunity to submit written comments, documents, records and other information relevant to the appeal. The individual making the decision must take all information into account regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination when making a decision. The Alliance documents when the member fails to submit relevant information.

5. AAH allows the member a reasonable opportunity, in person and in writing, to present evidence and testimony. AAH informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified and in the case of expedited resolution.

6. Professionals Deciding the Appeal

    - All appeals are reported to the appropriate level for review, medical necessity related appeals and appeals that do not require medical necessity review are resolved by a physician.
    - AAH appoints a reviewer that was not involved in the prior adverse decision to review the appeal. The reviewer will be neither the individual who made the adverse determination nor a subordinate of such individual.

7. Same-or-similar-specialist review

    - AAH ensures that the reviewer of the appeal involving clinical issues has appropriate training and experience in the same or similar specialty of medicine involved in the case must review the appeal. In cases where our internal medical staff does not have the appropriate training and experience to review, the case will be sent out for an external review by a certified agency.

- The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision.

- To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

    i. Includes treating the condition
    ii. Includes treating complications that may result from the service or procedure

    iii. Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate

8. AAH ensures the participation of individuals with authority to require corrective action, all appeals related to medical quality of care issues are immediately submitted to the medical director for action.

9. AAH provides the member or member's designated representative the opportunity to review the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Alliance in connection with any standard or expedited Appeal of an Adverse Benefit Determination. This information is provided free of charge and sufficiently in advance of the resolution timeframe.

10. **Acknowledgment:** Upon receiving the appeal:

    - **Preservice/prospective** acknowledgment letters will be dated and postmarked within five (5) calendar days of receipt for Standard Review;
    - **Postservice/retrospective** acknowledgment letters will be dated and postmarked within five (5) calendar days of receipt for Standard Review.

    The written appeal acknowledgement will advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal.

11. **Resolution:** Upon receiving the appeal:

    - **Preservice/prospective** AAH will resolve the appeal and provide the member with written notification of the decision within 30 calendar days.
    - **Postservice/retrospective** AAH will resolve the appeal and provide the provider with written notification of the decision within 30 calendar days.

    The written appeal decision will include the following elements, when applicable:

    - The specific reason for the appeal decision, in easy-to-understand language;

- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member can obtain a copy free of charge, upon request, of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member can obtain, upon request and at no additional charge, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents or records relied upon and documents and records submitted in the course of making the appeal decision;
- The notice will include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications and specialty of each clinical reviewer, also states that the reviewer did participate in the appeal review; and
- Notification on how to receive benefits while the hearing is pending and how to request the continuation of benefits;
- A description of the external review (DMHC, IMR, State Fair Hearing), as applicable, along with any relevant written procedures.

If the denial was overturned, the appeal resolution will state the decision and the date of the decision.

12. **Method of Filing:** AAH allows members to be represented by anyone they choose, including an attorney. A Member may choose to be represented in an appeal by a family member, friend, attorney, or other authorized representative. When an appeal is received from someone on the Member's behalf, the representative must have a current Appointment of Representation (AOR) on file prior to filing an appeal on the member's behalf.

    Appeals may be received either orally or in writing. The Alliance will make a reasonable effort to acquire the written consent from the member when a provider files on behalf of the member. If written consent is not received, the case will be closed as a grievance to notify the member as to why the appeal could not be processed.~~; however, will not delay processing of the appeal if not obtained.~~

    In addition, an oral Appeal (excluding expedited Appeals) are requested to be followed up by a written, signed Appeal. The date of the oral Appeal establishes the received date for the Appeal regardless of when a written appeal is received. The Alliance requests a member oral request for a standard Appeal be followed by a written confirmation of the Appeal. The Alliance will assist the member in preparing a written Appeal, including notifying the member of the location of the "Grievance Form" on the Alliance website or providing the "Grievance Form" upon request. The Alliance will also advise and assist the member is requesting continuation of benefits during the Appeal of the Adverse Benefit Determination. The Alliance will make a reasonable

effort to acquire the written, signed Appeal from the member; however, will not dismiss or delay processing the appeal if not obtained.

13. **Expedited Review:** Members are offered an expedited appeal for any urgent care requests:

    - Member or provider may file an expedited appeal either orally or in writing and no additional Member follow-up is required;
    - AAH informs the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing;
    - AAH grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility;
    - All expedited appeals are initially reviewed by clinical staff to review expedited status, if an appeal changes in status to a standard appeal, the appeal is transferred to the timeframe for standard resolution in accordance with § 438.408(b)(2);
    - AAH then sends the member written notification of the change from expedited to non-expedited appeal status within 2 days;
    - AAH makes expedited appeal decisions and notifies members and providers as expeditiously as the medical condition requires, but no later than 72 hours after the request, the Alliance records the time and date of the expedited Appeal receipt which drives the timeframe for resolution; and
    - AAH makes a reasonable effort to provide oral notice of expedited appeal decision.

14. **Extension of Timeframes:** The Alliance complies with DMHC requirements in accordance with Title 28, CCR, §1300.68(d)(3), the resolution, containing a written response to the Appeal shall be sent to the member within 30 calendar days of receipt. The Alliance will not allow any extension when processing an Adverse Benefit Determination Appeal.

15. **Upheld Decisions:** For Appeals not resolved wholly in favor of the member, the Alliance sends the member the Notice of Appeal Resolution and "Your Right" attachment. These documents are viewed as a "packet" and are sent in conjunction, the "packet" include:

    - **Notice of Appeal Resolution (NAR)**

        i. The results of the resolution and the date it was completed.
        ii. If the Alliance's denial determination is based in whole or in part on medical necessity, the Alliance includes in its written response the reasons for its determination and clearly states the criteria, clinical guidelines, or medical policies used in reaching the determination.

iii. If the Alliance's determination specifies the requested service is not a covered benefit, the Alliance includes in its written response the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response identifies the document and page where the provision is found, and directs the member to the applicable section of the contract containing the provision, or provides the a copy of the provision and explains in clear and concise language on how the exclusion is applied to the specific health care service or benefit requested.

- **"Your Rights" Attachment**

  i. The member's right to request a State Hearing no later than 120 calendar days from the date of the Alliance's written Appeal resolution and instructions on how to request a State Hearing.
  ii. The member's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, Section 438.420.
  iii. The member's right to request an IMR from the DMHC if the Alliance's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is an emergency service. The Alliance includes the IMR application, instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

16. **Overturned Decisions:** For Appeals resolved in favor of the member, written notice to the member includes the results of the resolution and the date it was completed. The written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned. The Notice of Appeal Resolution Packet for overturned decisions is sent to the member. The notice templates are approved by DHCS prior to use. If any changes are made to the templates, they are submitted to DHCS for review and approval prior to use.

    The Alliance authorizes or provides the disputed services promptly and as expeditiously as the member's condition requires when the decision to deny, limit, or delay services are reversed and were not furnished while the Appeal was pending. The services are authorized or provided no later than 72 hours from the date the determination is reversed.

17. **Linguistic and Cultural Needs:** The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through

translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Language assistance taglines are included with all acknowledgement and resolution letters, the taglines inform members of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

18. **Continued coverage pending outcome of appeal:** The Alliance will allow continued coverage, pending the outcome of an internal appeal of a concurrent care decision until:
    - The end of the approved treatment period, **or**
    - Determination of the appeal, subject to regulatory and contractual obligations.

DEFINITIONS / ACRONYMS

1. An **Adverse Benefit Determination** is defined to mean any of the following actions taken by the Alliance:

    a. The denial or limited authorization of a requested service, including determination based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner.
    e. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    f. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
    g. The denial of a beneficiary's request to dispute financial liability.

2. An **appeal** is defined as a review by the Alliance of an Adverse Benefit Determination.

3. A **preservice/prospective appeal** is a request to change an Adverse Benefit Determination for care or service that the AAH must approve, in whole or in part, in advance of the member obtaining care or services.

4. A **postservice/retrospective appeal** is a request to change an Adverse Benefit Determination for care or services that have already been received by the member.

5. An **expedited appeal** is a request to change an Adverse Benefit Determination for urgent care. **Urgent care** is medical care or treatment with respect to which application of the period for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, **or**
- In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

6. An **external appeal** is a request for an independent, external review of the final Adverse Benefit Determination made by the organization through its internal appeal process.

7. A **Notice of Action (NOA)** is a formal letter informing a Member and Provider of an Adverse Benefit Determination.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Compliance Department
- Provider Relations Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- MED-UM-0051 Timeliness of UM Decisions

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance Form
- Notice of Appeal Resolution
- "Your Rights"
- Adverse Benefit Determination Appeal Process Workflow – Standard
- Adverse Benefit Determination Appeal Process Workflow – Expedited
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

08/24/2017, 3/21/2019, 11/20/2019, 11/19/2020, 11/18/2021, 04/28/2022, 03/31/2023

REFERENCES

- NCQA UM 8: Policies for Appeals
- DHCS All Plan Letter 21-011
- CFR, Title 42, Section 438.410
- CCR, Title 28, Section 1300.68
- CCR, Title 28, Section 1300.68.01
- CFR, Title 42, Section 438.406

- H&S Code, Section 1367.01

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit includes reviewing notices to ensure the appropriate DHCS approved templates are utilized when informing members of a denial or appeal resolution.
d. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
e. Responses on the findings are sent to Compliance 30 days after the request;
f. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-008
Policy Name	Adverse Benefit Determination Appeals Process
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	12/17/2015
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("AAH") will maintain an established, impartial process for resolving members' appeals of an Adverse Benefit Determinations based on medical necessity and benefit determinations with regards to their care and service. Members may have only one level of appeal before they have exhausted their appeal rights with the Plan.

PROCEDURE

Alameda Alliance for Health ("AAH") has established and annually reviews and updates written policies and procedures for the submittal, processing and resolution of Utilization Management (UM) appeals. The policies and procedures apply to medical necessity and benefit appeal processing.

1. AAH provides a Notice of Action (NOA) that informs members and providers that a medical service has been denied, deferred, or modified. The notice also includes the timely filing requirements if the member chooses to appeal the determination.

   - AAH will allow at least 180 calendar days from the date of the NOA for our GroupCare member or member's representative to appeal the determination; and
   - AAH will allow at least 60 calendar days from the date of the NOA for our Medi-Cal member or member's representative to appeal the determination.

   If the case does not meet timely filing for either GroupCare or Medi-Cal, the case will be logged and closed as a grievance. The resolution will include the member's rights to appeal the determination.

2. AAH documents the substance of an appeal and actions taken including, but not limited to:

    - The member's reason for appealing the previous decision;
    - Additional clinical or other information provided with the appeal request;
    - Previous denial or appeal history; and
    - Follow-up activities associated with the denial and conducted before the current appeal.

3. AAH thoroughly investigates all appeals received, including the aspects of clinical care or condition involved, and document in the electronic system. Investigation may include a review of actions taken by AAH or the provider, obtaining relevant medical records, and/or review of clinical guidelines, criteria and protocols relevant to the substance of the appeal. Investigation shall include any written comment, documents or other information submitted by the Member or Member's representative.

4. AAH allows the member or member's designated representative the opportunity to submit written comments, documents, records and other information relevant to the appeal. The individual making the decision must take all information into account regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination when making a decision. The Alliance documents when the member fails to submit relevant information.

5. AAH allows the member a reasonable opportunity, in person and in writing, to present evidence and testimony. AAH informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified and in the case of expedited resolution.

6. Professionals Deciding the Appeal

    - All appeals are reported to the appropriate level for review, medical necessity related appeals and appeals that do not require medical necessity review are resolved by a physician.
    - AAH appoints a reviewer that was not involved in the prior adverse decision to review the appeal. The reviewer will be neither the individual who made the adverse determination nor a subordinate of such individual.

7. Same-or-similar-specialist review

    - AAH ensures that the reviewer of the appeal involving clinical issues has appropriate training and experience in the same or similar specialty of medicine involved in the case must review the appeal. In cases where our internal medical staff does not have the appropriate training and experience to review, the case will be sent out for an external review by a certified agency.

- The same-or-similar specialist may be the same individual designated to make the appeal decision or may be a separate reviewer who provides a recommendation to the individual making the decision.

- To be considered a same-or-similar specialist, the reviewing specialist's training and experience must meet the following criteria:

    i. Includes treating the condition
    ii. Includes treating complications that may result from the service or procedure

    iii. Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate

8. AAH ensures the participation of individuals with authority to require corrective action, all appeals related to medical quality of care issues are immediately submitted to the medical director for action.

9. AAH provides the member or member's designated representative the opportunity to review the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Alliance in connection with any standard or expedited Appeal of an Adverse Benefit Determination. This information is provided free of charge and sufficiently in advance of the resolution timeframe.

10. **Acknowledgment:** Upon receiving the appeal:

    - **Preservice/prospective** acknowledgment letters will be dated and postmarked within five (5) calendar days of receipt for Standard Review;
    - **Postservice/retrospective** acknowledgment letters will be dated and postmarked within five (5) calendar days of receipt for Standard Review.

    The written appeal acknowledgement will advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal.

11. **Resolution:** Upon receiving the appeal:

    - **Preservice/prospective** AAH will resolve the appeal and provide the member with written notification of the decision within 30 calendar days.
    - **Postservice/retrospective** AAH will resolve the appeal and provide the provider with written notification of the decision within 30 calendar days.

    The written appeal decision will include the following elements, when applicable:

    - The specific reason for the appeal decision, in easy-to-understand language;

- A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member can obtain a copy free of charge, upon request, of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Notification that the member can obtain, upon request and at no additional charge, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents or records relied upon and documents and records submitted in the course of making the appeal decision;
- The notice will include the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications and specialty of each clinical reviewer, also states that the reviewer did participate in the appeal review; and
- Notification on how to receive benefits while the hearing is pending and how to request the continuation of benefits;
- A description of the external review (DMHC, IMR, State Fair Hearing), as applicable, along with any relevant written procedures.

If the denial was overturned, the appeal resolution will state the decision and the date of the decision.

12. **Method of Filing:** AAH allows members to be represented by anyone they choose, including an attorney. A Member may choose to be represented in an appeal by a family member, friend, attorney, or other authorized representative. When an appeal is received from someone on the Member's behalf, the representative must have a current Appointment of Representation (AOR) on file prior to filing an appeal on the member's behalf.

    Appeals may be received either orally or in writing. The Alliance will make a reasonable effort to acquire the written consent from the member when a provider files on behalf of the member. If written consent is not received, the case will be closed as a grievance to notify the member as to why the appeal could not be processed.

    In addition, an oral Appeal (excluding expedited Appeals) are requested to be followed up by a written, signed Appeal. The date of the oral Appeal establishes the received date for the Appeal regardless of when a written appeal is received. The Alliance requests a member oral request for a standard Appeal be followed by a written confirmation of the Appeal. The Alliance will assist the member in preparing a written Appeal, including notifying the member of the location of the "Grievance Form" on the Alliance website or providing the "Grievance Form" upon request. The Alliance will also advise and assist the member is requesting continuation of benefits during the Appeal of the Adverse Benefit Determination. The Alliance will make a reasonable

effort to acquire the written, signed Appeal from the member; however, will not dismiss or delay processing the appeal if not obtained.

13. **Expedited Review:** Members are offered an expedited appeal for any urgent care requests:

    - Member or provider may file an expedited appeal either orally or in writing and no additional Member follow-up is required;
    - AAH informs the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing;
    - AAH grants an expedited review for all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility;
    - All expedited appeals are initially reviewed by clinical staff to review expedited status, if an appeal changes in status to a standard appeal, the appeal is transferred to the timeframe for standard resolution in accordance with § 438.408(b)(2);
    - AAH then sends the member written notification of the change from expedited to non-expedited appeal status within 2 days;
    - AAH makes expedited appeal decisions and notifies members and providers as expeditiously as the medical condition requires, but no later than 72 hours after the request, the Alliance records the time and date of the expedited Appeal receipt which drives the timeframe for resolution; and
    - AAH makes a reasonable effort to provide oral notice of expedited appeal decision.

14. **Extension of Timeframes:** The Alliance complies with DMHC requirements in accordance with Title 28, CCR, §1300.68(d)(3), the resolution, containing a written response to the Appeal shall be sent to the member within 30 calendar days of receipt. The Alliance will not allow any extension when processing an Adverse Benefit Determination Appeal.

15. **Upheld Decisions:** For Appeals not resolved wholly in favor of the member, the Alliance sends the member the Notice of Appeal Resolution and "Your Right" attachment. These documents are viewed as a "packet" and are sent in conjunction, the "packet" include:

    - **Notice of Appeal Resolution (NAR)**

        i. The results of the resolution and the date it was completed.
        ii. If the Alliance's denial determination is based in whole or in part on medical necessity, the Alliance includes in its written response the reasons for its determination and clearly states the criteria, clinical guidelines, or medical policies used in reaching the determination.

iii. If the Alliance's determination specifies the requested service is not a covered benefit, the Alliance includes in its written response the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response identifies the document and page where the provision is found, and directs the member to the applicable section of the contract containing the provision, or provides the a copy of the provision and explains in clear and concise language on how the exclusion is applied to the specific health care service or benefit requested.

- **"Your Rights" Attachment**

  i. The member's right to request a State Hearing no later than 120 calendar days from the date of the Alliance's written Appeal resolution and instructions on how to request a State Hearing.
  ii. The member's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, Section 438.420.
  iii. The member's right to request an IMR from the DMHC if the Alliance's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is an emergency service. The Alliance includes the IMR application, instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

16. **Overturned Decisions:** For Appeals resolved in favor of the member, written notice to the member includes the results of the resolution and the date it was completed. The written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned. The Notice of Appeal Resolution Packet for overturned decisions is sent to the member. The notice templates are approved by DHCS prior to use. If any changes are made to the templates, they are submitted to DHCS for review and approval prior to use.

    The Alliance authorizes or provides the disputed services promptly and as expeditiously as the member's condition requires when the decision to deny, limit, or delay services are reversed and were not furnished while the Appeal was pending. The services are authorized or provided no later than 72 hours from the date the determination is reversed.

17. **Linguistic and Cultural Needs:** The Alliance addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. All members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through

translations of grievance and appeals procedures, forms, and the Alliance responses to grievance and appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Language assistance taglines are included with all acknowledgement and resolution letters, the taglines inform members of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

18. **Continued coverage pending outcome of appeal:** The Alliance will allow continued coverage, pending the outcome of an internal appeal of a concurrent care decision until:
    - The end of the approved treatment period, **or**
    - Determination of the appeal, subject to regulatory and contractual obligations.

DEFINITIONS / ACRONYMS

1. An **Adverse Benefit Determination** is defined to mean any of the following actions taken by the Alliance:

    a. The denial or limited authorization of a requested service, including determination based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner.
    e. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    f. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
    g. The denial of a beneficiary's request to dispute financial liability.

2. An **appeal** is defined as a review by the Alliance of an Adverse Benefit Determination.

3. A **preservice/prospective appeal** is a request to change an Adverse Benefit Determination for care or service that the AAH must approve, in whole or in part, in advance of the member obtaining care or services.

4. A **postservice/retrospective appeal** is a request to change an Adverse Benefit Determination for care or services that have already been received by the member.

5. An **expedited appeal** is a request to change an Adverse Benefit Determination for urgent care. **Urgent care** is medical care or treatment with respect to which application of the period for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, **or**
- In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

6. An **external appeal** is a request for an independent, external review of the final Adverse Benefit Determination made by the organization through its internal appeal process.

7. A **Notice of Action (NOA)** is a formal letter informing a Member and Provider of an Adverse Benefit Determination.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Compliance Department
- Provider Relations Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- MED-UM-0051 Timeliness of UM Decisions

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance Form
- Notice of Appeal Resolution
- "Your Rights"
- Adverse Benefit Determination Appeal Process Workflow – Standard
- Adverse Benefit Determination Appeal Process Workflow – Expedited
- Grievance and Appeals Audit Universe Template
- Grievance and Appeals Audit Tool

REVISION HISTORY

08/24/2017, 3/21/2019, 11/20/2019, 11/19/2020, 11/18/2021, 04/28/2022, 03/31/2023

REFERENCES

- NCQA UM 8: Policies for Appeals
- DHCS All Plan Letter 21-011
- CFR, Title 42, Section 438.410
- CCR, Title 28, Section 1300.68
- CCR, Title 28, Section 1300.68.01
- CFR, Title 42, Section 438.406

- H&S Code, Section 1367.01

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis by the Compliance Department:

a. An universe is requested the month after the end of the quarter (See Attachment – G&A Audit Universe Template);
b. Compliance conducts a 30 file review audit (See Attachment – G&A Audit Tool);
c. Audit includes reviewing notices to ensure the appropriate DHCS approved templates are utilized when informing members of a denial or appeal resolution.
d. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
e. Responses on the findings are sent to Compliance 30 days after the request;
f. The audit findings are also reporting during the quarterly Compliance Committee.

2. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Quality Assurance. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A-009
Policy Name	Provider Grievances
Department Name	Complaints and Resolutions
Department Officer	Chief Operating Officer
Policy Owner	Director, Complaints and Resolutions
Line(s) of Business	Medi-Cal
Effective Date	07/09/2018
Approval/Revision Date	03/31/2023

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") maintains a formal procedure to accept, acknowledge, and resolve provider grievances. A provider of medical services may submit to the Alliance a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of payment or non-payment of a claim by the Alliance.

PROCEDURE

I. A provider grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member is processed in accordance with *G&A-008 Adverse Benefit Determination Appeals Process*.

II. A provider grievance concerning the processing of payment or non-payment of a claim by the Alliance is processed in accordance with *PDR-001 Provider Dispute Resolution Mechanism.*

III. A provider grievance concerning the processing of non-payment that is not related to a claim is outlined below:

   a. Contracted, subcontracted, and non-contracted providers are notified of this process through Provider Training and is also included in the Provider Manual that is located on the Alliance Website;

   b. **Submitting a Provider Grievance**

i. A provider grievance may be filed either orally or in writing directly to the Alliance within one hundred and eighty (180) days of the development of an issue requiring resolution; and
ii. Justification and supporting documentation must be provided with the written grievance.

c. **Acknowledgement of a Provider Grievance**

i. A written acknowledgement is provided within five (5) calendar days of receipt; and
ii. A written acknowledgement to the provider advises that the grievance has been received, the date of receipt, and who may be contacted about the grievance.

d. **Resolution of a Provider Grievance**

i. The Alliance will resolve the grievance by considering all available information and may request additional information or discuss the issue with the submitting provider;
ii. A written resolution is provided within thirty (30) calendar days of the receipt;
iii. In the event a resolution is not reached within thirty (30) calendar days, the Alliance will notify the provider in writing of the status of the grievance and provide an estimated completion date of resolution; and
iv. The resolution is final and will not be considered on appeal.

DEFINITIONS / ACRONYMS

1. "Provider Grievance" means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.

AFFECTED DEPARTMENTS/PARTIES

- Provider Relations Department
- Finance Department

RELATED POLICIES AND PROCEDURES

- G&A-008 Adverse Benefit Determination Appeals Process
- PDR-001 Provider Dispute Resolution Mechanism

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Provider Grievance Acknowledgement Letter
- Provider Grievance Resolution Letter

REVISION HISTORY

REFERENCES

- DHCS Contract, Exhibit A, Attachment 7

MONITORING

1. Staff Training

Staff training is conducted on an ad-hoc basis by either the Manager of Grievance and Appeals or the Director of Complaints and Resolutions. Training would consist of change to any applicable state regulation, and implementation of new or updated policy and procedures. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A – 010
Policy Name	Medi-Cal Rx Member Complaints and Grievances
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~03/31/2023~~11/15/2024

POLICY STATEMENT

As of April 1, 2021, Medi-Cal Rx will be responsible for managing the resolution of complaints and grievances raised by Alameda Alliance for Health ("Alliance") members, their authorized representatives, or other interested parties on behalf of the member, regarding a Medi-Cal Rx complaint or grievance.

PROCEDURE

1. Medi-Cal Rx complaints and grievances may be filed at any time, and are not subject to any specific timeframes, relative to the incident or action that is the subjects of the member's dissatisfaction. Complaints or grievances may be made orally or in writing, consistent with all applicable state and federal law requirements and Department of Health Care Services (DHCS) policies and procedures.

2. DHCS will oversee the Medi-Cal Rx complaint and grievance process to ensure appropriate and timely handling and resolution occurs.

3. The following outlines Medi-Cal Rx complaint and grievance processing requirements, which are intended to help manage transitional responsibilities for pharmacy-related complaints and grievances:

    a. Pharmacy-related complaints and grievances for services rendered or requested on or before March 31, 2021, by the Alliance, which are services that the Alliance was at risk for, will be fully processed by the Alliance in accordance with our policies and procedures.

b. Pharmacy-related complaints and grievances received on or after April 1, 2021, by the Medi-Cal Rx Customer Service Center (CSC) for services provided by the Alliance on or before March 31, 2021, will be forwarded by the Medi-Cal Rx CSC to the Alliance Grievance and Appeals Department for full resolution. The Medi-Cal Rx CSC will advise the Alliance member that they should contact the Alliance for such pharmacy-related complaints and grievances.

    i. Complaints and grievances received **via phone or secure chat** will be appropriately triaged and referred by the Medi-Cal Rx CSC to the Alliance via phone once they are determined to be an Alliance complaint or grievance, Medi-Cal Rx will make best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Alliance.
    ii. Complaints and grievances received **in writing**, will be appropriately triaged and mailed or faxed within three (3) calendar days.

c. The right of Alliance members to submit complaints and grievances to the Alliance for pharmacy-related services rendered on or before March 31, 2021, will not be impacted by Medi-Cal Rx.

d. Pharmacy-related complaints and grievances, received by the Alliance for Medi-Cal Rx services provided on or after April 1, 2021, will be forwarded by the Alliance to the Medi-Cal Rx CSC for resolution.

    i. Complaints and grievances coming in **via phone or secure website** will be appropriately triaged and referred to the Medi-Cal Rx CSC via phone once they are determined to be an Alliance complaint or grievance, the Alliance will make best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Medi-Cal Rx CSC.
    ii. Complaints and grievances received **in writing** will be appropriately triaged and mailed or faxed to the Medi-Cal Rx CSC within three (3) calendar days.

DEFINITIONS / ACRONYMS

1. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, other than an Adverse Benefit Determination made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
2. "Complaint" is the same as "grievance."
3. "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

AFFECTED DEPARTMENTS/PARTIES

- Member Services Department

- Grievance and Appeals Department

RELATED POLICIES AND PROCEDURES

- G&A – 001 Grievance System Description
- G&A – 002 Grievance Filing
- G&A – 003 Grievance Receipt, Review and Resolution
- G&A – 005 Expedited Review of Urgent Grievances
- MBR – 0024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DHCS Medi-Cal Rx Complaints/Grievances Policy
- DMHC All Plan Letter 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- Medi-Cal Rx Member Complaints and Grievances Workflow

REVISION HISTORY

11/18/2021, 03/31/2023

REFERENCES

- DHCS All Plan Letter 20-020 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis to ensure that Medi-Cal Rx member complaints and grievances are being forwarded to Medi-Cal Rx CSC in accordance with the requirements outlined in DHCS APL 20-020.

2. Staff Training

Staff training is conducted on an ad-hoc basis. Training would consist of change to any applicable state regulation, implementation of new or updated policy and procedures, and on any deficiencies or findings as a result or internal or external audits. Trainings are documented and require a signature of the participants involved.

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POLICY AND PROCEDURE

Policy Number	G&A – 010
Policy Name	Medi-Cal Rx Member Complaints and Grievances
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	11/15/2024

POLICY STATEMENT

As of April 1, 2021, Medi-Cal Rx will be responsible for managing the resolution of complaints and grievances raised by Alameda Alliance for Health ("Alliance") members, their authorized representatives, or other interested parties on behalf of the member, regarding a Medi-Cal Rx complaint or grievance.

PROCEDURE

1. Medi-Cal Rx complaints and grievances may be filed at any time, and are not subject to any specific timeframes, relative to the incident or action that is the subjects of the member's dissatisfaction. Complaints or grievances may be made orally or in writing, consistent with all applicable state and federal law requirements and Department of Health Care Services (DHCS) policies and procedures.

2. DHCS will oversee the Medi-Cal Rx complaint and grievance process to ensure appropriate and timely handling and resolution occurs.

3. The following outlines Medi-Cal Rx complaint and grievance processing requirements, which are intended to help manage transitional responsibilities for pharmacy-related complaints and grievances:

    a. Pharmacy-related complaints and grievances for services rendered or requested on or before March 31, 2021, by the Alliance, which are services that the Alliance was at risk for, will be fully processed by the Alliance in accordance with our policies and procedures.

b. Pharmacy-related complaints and grievances received on or after April 1, 2021, by the Medi-Cal Rx Customer Service Center (CSC) for services provided by the Alliance on or before March 31, 2021, will be forwarded by the Medi-Cal Rx CSC to the Alliance Grievance and Appeals Department for full resolution. The Medi-Cal Rx CSC will advise the Alliance member that they should contact the Alliance for such pharmacy-related complaints and grievances.

    i. Complaints and grievances received **via phone or secure chat** will be appropriately triaged and referred by the Medi-Cal Rx CSC to the Alliance via phone once they are determined to be an Alliance complaint or grievance, Medi-Cal Rx will make best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Alliance.
    ii. Complaints and grievances received **in writing**, will be appropriately triaged and mailed or faxed within three (3) calendar days.

c. The right of Alliance members to submit complaints and grievances to the Alliance for pharmacy-related services rendered on or before March 31, 2021, will not be impacted by Medi-Cal Rx.

d. Pharmacy-related complaints and grievances, received by the Alliance for Medi-Cal Rx services provided on or after April 1, 2021, will be forwarded by the Alliance to the Medi-Cal Rx CSC for resolution.

    i. Complaints and grievances coming in **via phone or secure website** will be appropriately triaged and referred to the Medi-Cal Rx CSC via phone once they are determined to be an Alliance complaint or grievance, the Alliance will make best efforts to immediately forward complaints and grievances for timely and accurate resolution by the Medi-Cal Rx CSC.
    ii. Complaints and grievances received **in writing** will be appropriately triaged and mailed or faxed to the Medi-Cal Rx CSC within three (3) calendar days.

DEFINITIONS / ACRONYMS

1. "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, other than an Adverse Benefit Determination made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
2. "Complaint" is the same as "grievance."
3. "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

AFFECTED DEPARTMENTS/PARTIES

- Member Services Department

- Grievance and Appeals Department

RELATED POLICIES AND PROCEDURES

- G&A – 001 Grievance System Description
- G&A – 002 Grievance Filing
- G&A – 003 Grievance Receipt, Review and Resolution
- G&A – 005 Expedited Review of Urgent Grievances
- MBR – 0024 Exempt Grievances

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- DHCS Medi-Cal Rx Complaints/Grievances Policy
- DMHC All Plan Letter 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- Medi-Cal Rx Member Complaints and Grievances Workflow

REVISION HISTORY

11/18/2021, 03/31/2023

REFERENCES

- DHCS All Plan Letter 20-020 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx

MONITORING

1. Internal Auditing

Auditing is done on a quarterly basis to ensure that Medi-Cal Rx member complaints and grievances are being forwarded to Medi-Cal Rx CSC in accordance with the requirements outlined in DHCS APL 20-020.

2. Staff Training

Staff training is conducted on an ad-hoc basis. Training would consist of change to any applicable state regulation, implementation of new or updated policy and procedures, and on any deficiencies or findings as a result or internal or external audits. Trainings are documented and require a signature of the participants involved.

POLICY AND PROCEDURE

Policy Number	G&A-011
Policy Name	UM Appeals System Controls
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	07/15/2021
Approval/Revision Date	~~10/19/2023~~11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has UM appeal system controls to protect data from being altered outside of prescribed protocols.

PROCEDURE

The Alliance has system controls specific to UM appeal dates that:

1. Defines the date of receipt consistent with NCQA requirements
    a. The date of receipt in the UM appeal system is defined as the date when the appeal is requested via telephone or when it arrives via fax or mail at the Alliance, even if it is not received by the Grievance and Appeals Department.
        i. Via Telephone. The time and date that the call was logged by the Member Services Department, the Grievance and Appeals Department, or the UM Department.
        ii. Via Fax. The time and date that the fax was received by the Alliance.
        iii. Via Mail. The time and date that the appeal was date stamped by the Facilities Department.
    b. The Alliance counts the time from the date when the Alliance receives the request, whether or not it is during business hours.
2. Defines the date of written notification consistent with NCQA requirements
    a. The date of written notification is when the Alliance gives written notification of decision to members and practitioners either via fax or mail.. .

Commented [KG1]: Per UM 5A (page: 269 / comment for UM 12A) - For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

b. An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

3. Recording dates in system:
    a. Date of Receipt. The Grievance and Appeals Department enters in the receipt date as defined in 1a. manually through our HealthSuite system via service requests. The date and time of receipt is entered through a service request that routes into our Quality Suite system where the UM appeal is then processed.
    b. Date of Written Notification. The Grievance and Appeals Department manually enters the written notification date as defined in 2a. in our Quality Suite system when the written notification is generated
4. Staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate:
    a. Circumstances when dates can be modified
        i. UM Appeal System Error. When there is a technical error in the system confirmed by the Information Technology Department.
            1. E.g. The system may show a wrong date despite the correct date having been entered by staff.
        ii. Administration Error. When a staff member, all levels and departments, enter the incorrect date or time into the system.
    b. Level of staff who are authorized to modify dates
        i. The Director of Quality Assurance or the Manager of Grievance and Appeals are authorized to modify received dates and written notification dates in the UM appeals system.
        ii. Grievance and Appeals Coordinators can modify the dates when approved by the director or manager. Documentation of approval is entered as a Log within the case.
    c. Level of staff who are authorized to void cases:
        i. Quality Assurance Specialist (2)
        ii. Lead Grievance and Appeals Coordinator
        iii. Supervisor, Grievance and Appeals
        iv. Sr. Manager, Grievance and Appeals
        v. Director, Quality Assurance
5. Tracking modified dates:
    a. The Quality Suite system documents the modification to the date, when the date was modified, and who modified the date in the “Audit” section of the system. The reason the date was modified is added as a log in the case.
    b. Cases can be voided under the following circumstances:
        i. Duplicate case
        ii. Case created under the wrong member

Quality Suite does not prevent any false modification of information; however, the audit report is able to identify all modifications made. Review of the audit report allows the Quality Assurance Specialist, Manager and Director of Quality Assurance to identify and analyze modifications made that do not meet the policy requirements.

6. All UM appeals system data is secured in accordance with our IT policy and procedures.
    a. Password-protecting electronic systems is outlined in IT-003 Password Management Policy, the policy includes our requirements for:
        i. Using strong passwords
        ii. Avoiding writing down passwords
        iii. User IDs and passwords unique to each user
        iv. Changing passwords periodically
    b. The Director of Quality Assurance provides access to Quality Suite. They will add the staff to the system with their windows log in user ID and create a temporary password for the staff to log in. Once they are able to log in the staff member will update their password.
    c. Access to the electronic systems is outlined in IT-010 Access Authorization Policy, the policy includes our requirements for:
        i. Limiting physical access to the system; therefore, preventing unauthorized access and changes to system data.
    d. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security is outlined in IT-009 Access Termination Policy.

DEFINITIONS / ACRONYMS

1. Quality Suite: The Alliance's UM Appeals Systems where appeals are processed in accordance with NCQA standards.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Utilization Management Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-008 Adverse Benefit Determination Appeal Process
- IT-003 Password Management Policy
- IT-009 Access Termination Policy
- IT-010 Access Authorization Policy
- CMP-019 Delegation Oversight
- CMP-020 Corrective Action Plan

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Grievance and Appeals Intake Workflow
- Expedited Appeals Checklist
- Standard Appeals Checklist

REVISION HISTORY

07/15/2021, 05/26/2022, 03/31/2023, 10/19/2023

REFERENCES

- NCQA UM 12: UM System Controls, Element B: UM Appeal System Controls

MONITORING

The Alliance conducts audits to identify and assess and ensure that this policy and procedure is followed.

1. Audit
    a. Annually, the Manager of Grievance and Appeals will identify a random sample of 5% or 50 files, whichever is fewer, from each applicable file type, to review against the system control requirements.
    b. All date modifications made in Quality Suite are tracked and accessible via the "Audit" section of the system.
    c. The Manager of Grievance and Appeals will generate a report, from Quality Suite, which includes all date modifications made, including the user who made modifications, what was modified, and the date and time modifications occurred. If needed, the auditor will go into the system to review supporting documentation to identify if the modification/change was warranted. If the Manager of Grievance and Appeals believes that the updates or modifications made to the appeals records are questionable after conducting the audit, then the manager will follow up with the appropriate staff member to determine the reason a change was made and to determine whether it was appropriate.
2. UM Appeals System Controls Oversight
    a. Annually the Alliance will report the following to HCQC:
        i. All modifications to UM appeal receipt and notification dates that did not meet policy.
        ii. Analyze all instances of modifications that did not meet policy for modification.
        iii. Take action on all findings and implement a quarterly monitoring process until improvement is demonstrated for one finding over three consecutive quarters.

POLICY AND PROCEDURE

Policy Number	G&A-011
Policy Name	UM Appeals System Controls
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	07/15/2021
Approval/Revision Date	11/15/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has UM appeal system controls to protect data from being altered outside of prescribed protocols.

PROCEDURE

The Alliance has system controls specific to UM appeal dates that:

1. Defines the date of receipt consistent with NCQA requirements
    a. The date of receipt in the UM appeal system is defined as the date when the appeal is requested via telephone or when it arrives via fax or mail at the Alliance, even if it is not received by the Grievance and Appeals Department.
        i. Via Telephone. The time and date that the call was logged by the Member Services Department, the Grievance and Appeals Department, or the UM Department.
        ii. Via Fax. The time and date that the fax was received by the Alliance.
        iii. Via Mail. The time and date that the appeal was date stamped by the Facilities Department.
    b. The Alliance counts the time from the date when the Alliance receives the request, whether or not it is during business hours.
2. Defines the date of written notification consistent with NCQA requirements
    a. The date of written notification is when the Alliance gives written notification of decision to members and practitioners either via fax or mail.. .

Commented [KG1]: Per UM 5A (page: 269 / comment for UM 12A) - For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

b. An appropriately written notification includes a complete explanation of the grounds for the upheld appeal decision, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

3. Recording dates in system:
    a. Date of Receipt. The Grievance and Appeals Department enters in the receipt date as defined in 1a. manually through our HealthSuite system via service requests. The date and time of receipt is entered through a service request that routes into our Quality Suite system where the UM appeal is then processed.
    b. Date of Written Notification. The Grievance and Appeals Department manually enters the written notification date as defined in 2a. in our Quality Suite system when the written notification is generated
4. Staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate:
    a. Circumstances when dates can be modified
        i. UM Appeal System Error. When there is a technical error in the system confirmed by the Information Technology Department.
            1. E.g. The system may show a wrong date despite the correct date having been entered by staff.
        ii. Administration Error. When a staff member, all levels and departments, enter the incorrect date or time into the system.
    b. Level of staff who are authorized to modify dates
        i. The Director of Quality Assurance or the Manager of Grievance and Appeals are authorized to modify received dates and written notification dates in the UM appeals system.
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REVISION HISTORY

07/15/2021, 05/26/2022, 03/31/2023, 10/19/2023

REFERENCES

- NCQA UM 12: UM System Controls, Element B: UM Appeal System Controls

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    a. Annually, the Manager of Grievance and Appeals will identify a random sample of 5% or 50 files, whichever is fewer, from each applicable file type, to review against the system control requirements.
    b. All date modifications made in Quality Suite are tracked and accessible via the "Audit" section of the system.
    c. The Manager of Grievance and Appeals will generate a report, from Quality Suite, which includes all date modifications made, including the user who made modifications, what was modified, and the date and time modifications occurred. If needed, the auditor will go into the system to review supporting documentation to identify if the modification/change was warranted. If the Manager of Grievance and Appeals believes that the updates or modifications made to the appeals records are questionable after conducting the audit, then the manager will follow up with the appropriate staff member to determine the reason a change was made and to determine whether it was appropriate.
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        iii. Take action on all findings and implement a quarterly monitoring process until improvement is demonstrated for one finding over three consecutive quarters.

POLICY AND PROCEDURE

Policy Number	QI-107
Policy Name	Appointment Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	9/4/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") complies with the access and availability regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

The Alliance shall implement and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care for all applicable provider types, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Access and availability procedures will also include procedures for follow-up on missed appointments. Alliance practitioners and medical groups, including primary care providers (PCPs), obstetrics or gynecology (OB/GYN) practitioners, are required to meet the access standards delineated below to participate in the Alliance network. Providers contracted with the Alliance are responsible for providing access to care for members twenty-four (24) hours per day, seven (7) days a week. All delegated medical groups, including contracted behavioral health providers, are required to provide or ensure that twenty-four (24) hours per day, seven (7) days a week access

to medical care for members is available, including after business hours telephone access to a physician or a triage system utilizing specific licensed practitioners.

The Alliance ensures ongoing oversight and monitoring of its provider network through the Access and Availability (A&A) Committee. Quality Improvement (QI) staff will engage in any of the following actions with providers failing to meet the access and availability standards set within this policy:

A. Provider education/re-education and outreach (face-to-face, verbal, and/or written)
B. Written corrective action plans (CAPs)
C. Resurveying within a specified timeframe to assess/reassess compliance with timely access standard(s)
D. Discussions at Joint Operations Meetings (for delegates)
E. Referral to the A&A Committee for discussion and recommendations for next steps
F. Referral to the Credentialing Committee (CC), and/or to the Peer Review and Credentialing Committee (PRCC) as appropriate, for discussion and recommendations for next steps
G. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
H. Other actions as appropriate

PROCEDURE

A. Appointment Access Standards

Please refer to the table below for the access and availability regulatory and contractual requirements, per DMHC and DHCS regulations.

Life-Threatening Emergency:

- Immediately, twenty-four (24) hours a day, seven (7) days a week

A life-threatening emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A patient's health being placed in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily organ or part

Non-Life-Threatening Emergency

- Within six (6) hours of the request

The Alliance communicates appointment access standards to providers through the Alliance Provider Manual, during orientation training for new providers, through Provider Bulletins, through quarterly provider packets, and through fax blasts.

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* require PA	48 Hours of the Request
Urgent Appointment that *requires* PA[1]	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent **Specialist** Appointment	15 Business Days of the Request
Non-Urgent **Behavioral Health** Appointment	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

[1] Prior authorization

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure Proper Emergency Instructions	
Language Services – Provide 24 Hour Interpretive Services	

B. LTSS Timely Access Network Standards

The Alliance's Utilization Management Department monitors our LTSS facility against the following timely access network standards

LTSS TIMELY ACCESS NETWORK STANDARDS	
Provider Type:	**Standard:**
Skill Nursing Facility	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 5 business days of request
Community Based Adult Services (CBAS)	
Initial	Within 5 business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	6 months

*The DMHC Timely Access standard is 15 Business days for Psychiatrists; however, to comply with the NCQA accreditation standards of 10 Business days, Alliance uses the more stringent standards.

C. Shortening or Extending Appointment Timeframes

The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.

D. Telephone Access Standards – For the Plan

During normal business hours, the wait time for members to speak by telephone with an Alliance Member Services representative knowledgeable and competent in addressing members questions and concerns shall not exceed ten (10) minutes.

E. Telephone Access Standards – For the **Provider Office**

During normal business hours, the wait time for members to speak by telephone with a provider staff member knowledgeable and competent in addressing members' questions and concerns shall not exceed ten (10) minutes.

Providers comply with the standards for responding to members phone calls by ensuring: A. Appropriate personnel handle emergent, urgent, and medical advice telephone calls,

B. The telephone answering machine, voicemail system, or answering service is used whenever office staff does not directly answer phone calls, and

C. The telephone system answering service, recorded telephone information, or recording device are periodically checked and updated.

F. After Hours Access to Primary Care Providers (PCPs), Specialists and Behavioral Health Providers

The Alliance requires that PCPs, specialists, and behavioral health providers have arrangements in place for telephone access twenty-four (24) hours per day, seven (7) days per week, per DHCS regulatory requirements. Providers are required to meet minimum standards for access to after-hours care by including the following information in their after-hours message:

- Identification of provider's name,
- Information regarding office hours,
- Instructions on what to do in a medical emergency,
- Option to leave a message for the provider, and
- The anticipated length of wait time for a return call from the provider.

The waiting time for PCP, specialist, and behavioral health provider telephone triage or screening shall not exceed thirty (30) minutes, during **and** after normal business hours.

The Alliance, in conjunction with its survey vendor, annually conducts an after-hours survey to monitor provider compliance with after-hours care. Providers who may be excused from the After- Hours survey include:

- Pathologists
- Radiologists
- Emergency Medicine providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser providers
- Chiropractors
- Registered Dieticians
- General Hospitalists
- Medical Geneticists
- Anesthesiologists
- Applied Behavioral Analysis (ABA) Providers
- Board Certified Behavioral Analyst (BCBA) Providers

G. Missed Appointments

When a member's scheduled appointment is missed, Alliance providers must follow-up with the member to schedule another appointment based on the initial type of care required (e.g., urgent, routine, preventive, prenatal, etc.).

Alliance physicians must have a process in place to follow up on missed or canceled appointments that includes the following at a minimum:

1. Documentation of the missed or canceled appointment in the member's medical record.
2. Review of the potential impact of the missed or canceled appointment on the member's health status, including review of the reason for the appointment by a licensed staff member of the physician's office (RN, PA, NP, or MD).
3. Documentation in the medical record describing the follow up for the missed or canceled appointment, including one of the following actions: no action if there is no effect on the member due to the missed appointment; or a letter or phone call to the member as appropriate, given the type of appointment missed and the potential impact on the member. The medical record entry must be signed or co-signed by the member's assigned PCP or covering physician.
4. Three (3) attempts, at least one (1) by phone and one (1) by mail, made in attempting to contact a member if the member's health status is potentially at significant risk due to missed or canceled appointments. Examples include members with serious chronic illnesses, members with test results that are significant (e.g., abnormal Pap smear), and members judged by the treating physician to be at risk for other reasons. Documentation of the attempts must be entered in the member's medical record and copies of letters retained.
5. Office staff in Alliance physician offices that are trained in, and familiar with, the missed or canceled appointment procedure specific to their site.

The Alliance monitors missed, canceled, and rescheduled appointments through facility site review (FSR) evaluations and medical record review (MRR) evaluations.

H. Emergency Services

The Alliance has continuous availability, accessibility, as well as adequate numbers of

a) institutional facilities,
b) service locations,
c) service sites,
d) professional allied, and
e) supportive paramedical personnel

to provide covered services including the provision of all medical care necessary under emergency circumstances. The Alliance network of physicians and hospitals are required to provide access to appropriate triage personnel and emergency services twenty-four (24) hours per day, seven (7) days a week.

The Alliance will include covered ambulance services for the area served by the plan to transport the member to the nearest twenty-four (24) hour emergency facility with physician coverage, designated by the Alliance. The Alliance evaluates inappropriate use of emergency room services, issues regarding member access to health care, and under- or over-utilization of services through:

a) assessment of encounter data,
b) special studies,
c) claims data,
d) grievances and appeals,
e) Potential Quality Issues (PQIs)
f) medical record audits, and
g) medical oversight of the Quality Improvement Health Equity Committee (QIHEC).

I. Follow-up of Emergency Room or Urgent Care Visits

Hospitals and medical groups are responsible for informing PCPs of members that receive an emergency room (ER) or urgent care visit including information regarding needed follow-up, as needed. PCPs are responsible for obtaining necessary medical records from an ER or urgent care visit and arranging any needed follow-up care.

J. Open Access to OB/GYN Services

In accordance with state law, the Alliance requires that all practitioners and medical groups allow women direct access without referral for OB/GYN services to a participating OB/GYN or Family Practitioner (FP) that meets Alliance credentialing standards.

The Alliance requires members to obtain direct access only from those OB/GYNs or FPs within the group or Alliance network to which they are assigned, and to use contracted/assigned hospitals for facility-based services.

The Alliance requires OB/GYNs or FPs to follow prior authorization guidelines for any specialized procedures or other treatments outside of a "well woman" exam or routine OB/GYN care. The Alliance requires OB/GYNs or FPs to communicate with the member's PCP regarding the member's condition, treatment, and follow-up care.

K. Access to Sensitive Services for Adults

Providers and practitioners must have procedures in place to ensure that adults have access to sensitive and confidential services. Sensitive services do not require prior authorization and can be obtained by out-of-network providers.

L. Access to Sensitive Services for Minors

Minors and adolescents have the right to consent to and receive sensitive services without parental consent. Sensitive services do not require prior authorization and can be obtained by out-of- network providers.

Alliance members aged 12-21 may access sensitive services through their PCP, or through other network physicians within the medical group or Alliance network, and in the case of certain services for Medi-Cal Members, any qualified practitioner (See UM-029 for prior authorization details).

a) Sensitive services may include, but are not limited to, the following:
    i. Treatment for sexual assault, including rape.
    ii. Pregnancy related services.
    iii. Family planning services.
    iv. Sexually transmitted disease diagnosis and/or treatment.
    v. HIV testing and counseling.
    vi. Abortion services
b) Members are bound by the rules or procedures required for the specific services they are accessing.
c) Members are informed of their rights to access sensitive services through the Member Handbook

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DEFINITIONS / ACRONYMS

Appointment waiting time – The time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered healthcare services...

Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule – A schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence for preventive pediatric health care **(www.aap.org/enus/Documents/periodicity_schedule.pdf).**

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

Non-urgent care – Routine appointments for non-urgent conditions.

Preventive care – Health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by sections 1345(b)(5),1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).

Provider - Physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Triage or screening - The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Triage or screening waiting time - The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

Urgent care – Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

UM-029 Sensitive Services

UM-048 Triage and Screening Services

PRV-003 Provider Network Capacity Standards

QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey
CLS-003 Language Assistance Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

After-Hours Survey Tool
Facility Site Review Tool
Medical Record Review Tool
Provider Appointment Availability Survey
Tool Alliance Timely Access Standards

REVISION HISTORY

3/31/2016, 3/1/2018, 7/19/2018, 1/17/2019, 3/2120/19, 3/19/2020, 11/23/2021, 6/28/2022, 03/21/2023, 05/02/2023,9/19/2023, 12/19/2023, 6/12/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Access and
Availability Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)
DHCS Contract Exhibit A, Attachment 10, Scope of Services
Title 28, CCR, Section 1300.80 Medical Survey Procedures
DHCS All Plan Letter 15-020 Abortion Services
DHCS All Plan Letter 21-006 Network Certification Requirements
NCQA 2020 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services
DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

MONITORING

The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance network. The A&A Committee reports to the Quality Improvement Health Equity Committee annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	QI-107
Policy Name	Appointment Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	94/~~417~~/2024
Administrative Oversight Committee Approval Date	6/12/2024

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The Alliance ensures ongoing oversight and monitoring of its provider network through the Access and Availability (A&A) Committee. Quality Improvement (QI) staff will engage in any of the following actions with providers failing to meet the access and availability standards set within this policy:

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B. Written corrective action plans (CAPs)
C. Resurveying within a specified timeframe to assess/reassess compliance with timely access standard(s)
D. Discussions at Joint Operations Meetings (for delegates)
E. Referral to the A&A Committee for discussion and recommendations for next steps
F. Referral to the Credentialing Committee (CC), and/or to the Peer Review and Credentialing Committee (PRCC) as appropriate, for discussion and recommendations for next steps
G. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
~~G.~~ H. Other actions as appropriate

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PROCEDURE

A. Appointment Access Standards
Please refer to the table below for the access and availability regulatory and contractual requirements, per DMHC and DHCS regulations.

Life-Threatening Emergency:

- ~~□~~ Immediately, twenty-four (24) hours a day, seven (7) days a week

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A life-threatening emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A patient's health being placed in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily organ or part

Non-Life-Threatening Emergency

- Within six (6) hours of the request

The Alliance communicates appointment access standards to providers through the Alliance Provider Manual, during orientation training for new providers, through Provider Bulletins, through quarterly provider packets, and through fax blasts.

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* require PA	48 Hours of the Request
Urgent Appointment that *requires* PA[1]	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent **Specialist** Appointment	15 Business Days of the Request
Non-Urgent **Behavioral Health** Appointment	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

[1] Prior authorization

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure Proper Emergency Instructions	
Language Services – Provide 24 Hour Interpretive Services	

B. LTSS Timely Access Network Standards

The Alliance's Utilization Management Department monitors our LTSS facility against the following timely access network standards

LTSS TIMELY ACCESS NETWORK STANDARDS	
Provider Type:	**Standard:**
Skill Nursing Facility	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 5 business days of request
Community Based Adult Services (CBAS)	
Initial	Within 5 business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	6 months

*The DMHC Timely Access standard is 15 Business days for Psychiatrists; however, to comply with the NCQA accreditation standards of 10 Business days, Alliance uses the more stringent standards.

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C. Shortening or Extending Appointment Timeframes
The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.

D. Telephone Access Standards – For the Plan
During normal business hours, the wait time for members to speak by telephone with an Alliance Member Services representative knowledgeable and competent in addressing members questions and concerns shall not exceed ten (10) minutes.

E. Telephone Access Standards – For the **Provider Office**
During normal business hours, the wait time for members to speak by telephone with a provider staff member knowledgeable and competent in addressing members' questions and concerns shall not exceed ten (10) minutes.

Providers comply with the standards for responding to members phone calls by ensuring: A.

Appropriate personnel handle emergent, urgent, and medical advice telephone calls,

B. The telephone answering machine, voicemail system, or answering service is used whenever office staff does not directly answer phone calls, and

C. The telephone system answering service, recorded telephone information, or recording device are periodically checked and updated.

F. After Hours Access to Primary Care Providers (PCPs), Specialists and Behavioral Health Providers

The Alliance requires that PCPs, specialists, and behavioral health providers have arrangements in place for telephone access twenty-four (24) hours per day, seven (7) days per week, per DHCS regulatory requirements. Providers are required to meet minimum standards for access to after-hours care by including the following information in their after-hours message:

- Identification of provider's name,
- Information regarding office hours,
- Instructions on what to do in a medical emergency,
- Option to leave a message for the provider, and
- The anticipated length of wait time for a return call from the provider.

The waiting time for PCP, specialist, and behavioral health provider telephone triage or screening shall not exceed thirty (30) minutes, during **and** after normal business hours.

The Alliance, in conjunction with its survey vendor, annually conducts an after-hours survey to monitor provider compliance with after-hours care. Providers who may be excused from the After- Hours survey include:

- Pathologists
- Radiologists
- Emergency Medicine providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser providers
- Chiropractors
- Registered Dieticians
- General Hospitalists
- Medical Geneticists
- Anesthesiologists
- Applied Behavioral Analysis (ABA) Providers
- Board Certified Behavioral Analyst (BCBA) Providers

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G. Missed Appointments

When a member's scheduled appointment is missed, Alliance providers must follow-up with the member to schedule another appointment based on the initial type of care required (e.g., urgent, routine, preventive, prenatal, etc.).

Alliance physicians must have a process in place to follow up on missed or canceled appointments that includes the following at a minimum:

1. Documentation of the missed or canceled appointment in the member's medical record.
2. Review of the potential impact of the missed or canceled appointment on the member's health status, including review of the reason for the appointment by a licensed staff member of the physician's office (RN, PA, NP, or MD).
3. Documentation in the medical record describing the follow up for the missed or canceled appointment, including one of the following actions: no action if there is no effect on the member due to the missed appointment; or a letter or phone call to the member as appropriate, given the type of appointment missed and the potential impact on the member. The medical record entry must be signed or co-signed by the member's assigned PCP or covering physician.
4. Three (3) attempts, at least one (1) by phone and one (1) by mail, made in attempting to contact a member if the member's health status is potentially at significant risk due to missed or canceled appointments. Examples include members with serious chronic illnesses, members with test results that are significant (e.g., abnormal Pap smear), and members judged by the treating physician to be at risk for other reasons. Documentation of the attempts must be entered in the member's medical record and copies of letters retained.
5. Office staff in Alliance physician offices that are trained in, and familiar with, the missed or canceled appointment procedure specific to their site.

The Alliance monitors missed, canceled, and rescheduled appointments through facility site review (FSR) evaluations and medical record review (MRR) evaluations.

H. Emergency Services

The Alliance has continuous availability, accessibility, as well as adequate numbers of

a) institutional facilities,
b) service locations,
c) service sites,
d) professional allied, and
e) supportive paramedical personnel

to provide covered services including the provision of all medical care necessary under emergency circumstances. The Alliance network of physicians and hospitals are required to provide access to appropriate triage personnel and emergency services twenty-four (24) hours per day, seven (7) days a week.

The Alliance will include covered ambulance services for the area served by the plan to transport the member to the nearest twenty-four (24) hour emergency facility with physician coverage, designated by the Alliance. The Alliance evaluates inappropriate use of emergency room services, issues regarding member access to health care, and under- or over-utilization of services through:

a) assessment of encounter data,
b) special studies,
c) claims data,
d) grievances and appeals,
e) Potential Quality Issues (PQIs)
f) medical record audits, and
g) medical oversight of the Quality Improvement Health Equity Committee (QIHEC).

I. Follow-up of Emergency Room or Urgent Care Visits

Hospitals and medical groups are responsible for informing PCPs of members that receive an emergency room (ER) or urgent care visit including information regarding needed follow-up, as needed. PCPs are responsible for obtaining necessary medical records from an ER or urgent care visit and arranging any needed follow-up care.

J. Open Access to OB/GYN Services

In accordance with state law, the Alliance requires that all practitioners and medical groups allow women direct access without referral for OB/GYN services to a participating OB/GYN or Family Practitioner (FP) that meets Alliance credentialing standards.

The Alliance requires members to obtain direct access only from those OB/GYNs or FPs within the group or Alliance network to which they are assigned, and to use contracted/assigned hospitals for facility-based services.

The Alliance requires OB/GYNs or FPs to follow prior authorization guidelines for any specialized procedures or other treatments outside of a "well woman" exam or routine OB/GYN care. The Alliance requires OB/GYNs or FPs to communicate with the member's PCP regarding the member's condition, treatment, and follow-up care.

K. Access to Sensitive Services for Adults

Providers and practitioners must have procedures in place to ensure that adults have access to sensitive and confidential services. Sensitive services do not require prior authorization and can be obtained by out-of-network providers.

L. Access to Sensitive Services for Minors

Minors and adolescents have the right to consent to and receive sensitive services without parental consent. Sensitive services do not require prior authorization and can be obtained by out-of- network providers.

Alliance members aged 12-21 may access sensitive services through their PCP, or through other network physicians within the medical group or Alliance network, and in the case of certain services for Medi-Cal Members, any qualified practitioner (See UM-029 for prior authorization details).

a) Sensitive services may include, but are not limited to, the following:
   i. Treatment for sexual assault, including rape.
   ii. Pregnancy related services.
   iii. Family planning services.
   iv. Sexually transmitted disease diagnosis and/or treatment.
   v. HIV testing and counseling.
   vi. Abortion services
b) Members are bound by the rules or procedures required for the specific services they are accessing.
c) Members are informed of their rights to access sensitive services through the Member Handbook

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DEFINITIONS / ACRONYMS

Appointment waiting time – The time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered healthcare services...

Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule – A schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence for preventive pediatric health care **(www.aap.org/enus/Documents/periodicity_schedule.pdf).**

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

Non-urgent care – Routine appointments for non-urgent conditions.

Preventive care – Health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by sections 1345(b)(5),1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).

Provider - Physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Triage or screening - The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Triage or screening waiting time - The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

Urgent care – Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

UM-029 Sensitive Services

UM-048 Triage and Screening Services

PRV-003 Provider Network Capacity Standards

QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey
CLS-003 Language Assistance Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

After-Hours Survey Tool
Facility Site Review Tool
Medical Record Review Tool
Provider Appointment Availability Survey
Tool Alliance Timely Access Standards

REVISION HISTORY

3/31/2016, 3/1/2018, 7/19/2018, 1/17/2019, 3/2120/19, 3/19/2020, 11/23/2021, 6/28/2022, 03/21/2023, 05/02/2023,9/19/2023, 12/19/2023, 6/12/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Access and
Availability Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)
DHCS Contract Exhibit A, Attachment 10, Scope of Services
Title 28, CCR, Section 1300.80 Medical Survey Procedures
DHCS All Plan Letter 15-020 Abortion Services
DHCS All Plan Letter 21-006 Network Certification Requirements
NCQA 2020 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services
DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

MONITORING

The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance network. The A&A Committee reports to the Quality Improvement Health Equity Committee annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE TEMPLATE

Policy Number	QI-116
Policy Name	Provider Appointment Availability Survey (PAAS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	9/4/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") conducts an annual Provider Appointment Availability Survey (PAAS) in accordance with the Department of Managed Health Care (DMHC) survey methodology. The survey is designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members, including:

1. Ensuring members timely access to and availability of covered quality health care services that are appropriate for their patients' condition.
2. Establishing and maintaining a provider network, policies and procedures, and quality assurance that ensure compliance with clinically appropriate standards.
3. Maintaining efficient processes necessary for members to obtain covered services as appropriate (e.g., referral and prior authorization process); and
4. Maintaining a system to ensure members are seen in a timely manner.

PROCEDURE

A. Provider Appointment Availability Survey (PAAS) Methodology

1) The Alliance conducts the PAAS to measure provider compliance with DMHC access and availability standards in accordance with the current DMHC PAAS methodology.
2) Dependent upon provider type, the Alliance uses one of five DMHC-developed survey tools: the primary care provider (PCP) Survey Tool, the Specialist Provider Survey Tool, the Psychiatrist Survey Tool, the Non-Physician Mental Health (NPMH) Provider Survey Tool; and the Ancillary Provider Survey Tool.
3) The Alliance Analytics Department selects a random sample of providers from its provider network based on criteria set forth in the DMHC PAAS methodology. While DMHC PAAS methodology may change each year, the samples selected include the following:
   i. PCPs: Primary Care Physicians and Non-Physician Medical Practitioners providing primary care
   ii. Specialist Physicians: Cardiovascular Disease, Endocrinology, Gastroenterology, Dermatology, Neurology, Oncology, Ophthalmology, Otolaryngology, Pulmonology, and Urology
   iii. Psychiatrists
   iv. NPMH Providers: Licensed Professional Clinical Counselor (LPCC), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker
   v. Ancillary Service Providers: Facilities or entities providing mammogram or physical therapy appointments

4) The survey questions cover appointment availability standards:
   a. PCPs
      i. Urgent appointments (within 48 hours of request)
      ii. Routine appointments (within 10 business days of request)
   b. Specialists
      i. Urgent appointment (within 96 hours of request)
      ii. Routine appointment (within 15 business days of request)
   c. Psychiatrists

i. Urgent appointments (within 96 hours of request)

ii. Routine appointments (within 15 business days of request)

d. NPMH Providers

i. Urgent appointments (within 96 hours of request)

ii. Routine appointments (within 10 business days of request)

iii. Follow-up non-urgent appointments (within 10 business days of the prior appointment)

e. Ancillary Service Providers

i. Routine appointments (within 15 business days of request)

B. PAAS Analysis and Report

1) Designated Quality Improvement (QI) staff report the qualitative and quantitative results of the PAAS for review and recommendations to the Access and Availability (A&A) Committee.
2) The PAAS results, conclusions and recommendations are then reported to the Quality Improvement Health Equity Committee (QIHEC) for feedback and approval.
3) Delegated and directly contracted providers and groups are notified of the results of the PAAS with aggregate compliance rates.
    i. Providers, groups, and delegates found non-compliant with the standards are issued a corrective action plan (CAP) and are re-educated on the DMHC's appointment availability standards.
    ii. Providers, groups, and delegates found non-responsive to the survey are issued a CAP and are re-educated on the DMHC's appointment availability standards.
4) PAAS results, conclusions and recommendations are incorporated into the annual QI Program Evaluation and QI Program Work Plan for the upcoming year. The QI Program Evaluation is reported annually to the Department of Health Care Services (DHCS).
5) The Senior Director of Quality continuously monitors, tracks, and analyzes access and availability rates, continuity of care, and utilization satisfaction indicators to detect incidents, trends, and patterns of dissatisfaction with its provider network. QI staff analyze the data to identify opportunities for improvement with:
    i. Systemic operations issues/problems
    ii. Complaint types and resolutions; and/or

iii. Member identified needs

DEFINITIONS / ACRONYMS

Patterns of Non-Compliance means any of the following:

(A) For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers and 80% for NPMH provider follow-up appointments, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific net had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointment (All Provider Survey Types) field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.

(B) The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of noncompliance that is reasonably related:

i. Each instance is a violation of the same standard set forth in subsection (c) of this Rule;

ii. Each instance involves the samenetwork;

a. Each instance involves the same provider group, or subcontracted plan;
b. Each instance involves the same provider type;
c. Each instance involves the same network provider;
d. Each instance occurs in the same region. For purposes of the subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;
e. The number of enrollees in health plan's network and the total number of instances identified as part of a pattern;
f. Whether each instance occurred within the same twelve-month period; or
g. Whether each instance involves the same category of health care services.

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
QI-104 Potential Quality Issues (PQIs)
QI-105 FSRs MRRs and PARS
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

QI Program Evaluation
QI Work Plan
DMHC PAAS Survey Tools (PCP, Specialist, Psychiatrist, NPMH, Ancillary)

REVISION HISTORY

3/31/2016, 3/9/2017, 3/01/2018, 01/17/2019, 5/16/2019, 3/19/2020, 05/20/2021, 06/28/2022, 03/21/2023 , 6/12/2024

REFERENCES

DMHC PAAS Methodology, Measurement Year 2019
DMHC All Plan Letter 19-008 Timely Access Compliance Reports Measurement Year 2019
APL 24-017 (OPM)

MONITORING

Any findings and recommendations are reported quarterly to the A&A Committee and to the QIHEC. The Committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care.

This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The Committees may recommend CAPs be issued by QI staff and Provider Services. Compliance also reviews the PAAS report on an annual basis. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE TEMPLATE

Policy Number	QI-116
Policy Name	Provider Appointment Availability Survey (PAAS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	93/46/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") conducts an annual Provider Appointment Availability Survey (PAAS) in accordance with the Department of Managed Health Care (DMHC) survey methodology. The survey is designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members, including:

1. Ensuring members timely access to and availability of covered quality health care services that are appropriate for their patients' condition.
2. Establishing and maintaining a provider network, policies and procedures, and quality assurance that ensure compliance with clinically appropriate standards.
3. Maintaining efficient processes necessary for members to obtain covered services as appropriate (e.g., referral and prior authorization process); and
4. Maintaining a system to ensure members are seen in a timely manner.

PROCEDURE

A. Provider Appointment Availability Survey (PAAS) Methodology

1) The Alliance conducts the PAAS to measure provider compliance with DMHC access and availability standards in accordance with the current DMHC PAAS methodology.
2) Dependent upon provider type, the Alliance uses one of five DMHC-developed survey tools: the primary care provider (PCP) Survey Tool, the Specialist Provider Survey Tool, the Psychiatrist Survey Tool, the Non-Physician Mental Health (NPMH) Provider Survey Tool; and the Ancillary Provider Survey Tool.
3) The Alliance Analytics Department selects a random sample of providers from its provider network based on criteria set forth in the DMHC PAAS methodology. While DMHC PAAS methodology may change each year, the samples selected include the following:
   i. PCPs: Primary Care Physicians and Non-Physician Medical Practitioners providing primary care
   ii. Specialist Physicians: Cardiovascular Disease, Endocrinology, ~~and~~ Gastroenterology, Dermatology, Neurology, Oncology, Ophthalmology, Otolaryngology, Pulmonology, and Urology
   iii. Psychiatrists
   ~~iii.~~iv. ~~iv~~. NPMH Providers: Licensed Professional Clinical Counselor (LPCC), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker
   v. Ancillary Service Providers: Facilities or entities providing mammogram or physical therapy appointments

4) The survey questions cover appointment availability standards:

~~4)~~ a. PCPs
   i. Urgent appointments (within 48 hours of request)
   ii. Routine appointments (within 10 business days of request)
b. Specialists
   i. ~~i.~~ Urgent appointment (within 96 hours of request)
   ii. ~~ii~~. Routine appointment (within 15 business days of request)

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c. Psychiatrists

i. Urgent appointments (within 96 hours of request)

ii. Routine appointments (within 15 business days of request)

d. NPMH Providers

i. Urgent appointments (within 96 hours of request)

ii. Routine appointments (within 10 business days of request)

iii. Follow-up non-urgent appointments (within 10 business days of the prior appointment)

e. Ancillary Service Providers

i. Routine appointments (within 15 business days of request)

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B. PAAS Analysis and Report

1) Designated Quality Improvement (QI) staff report the qualitative and quantitative results of the PAAS for review and recommendations to the Access and Availability (A&A) Committee.
2) The PAAS results, conclusions and recommendations are then reported to the Quality Improvement Health Equity Committee (QIHEC) for feedback and approval.
3) Delegated and directly contracted providers and groups are notified of the results of the PAAS with aggregate compliance rates.
   i. ~~i.~~ Providers, groups, and delegates found non-compliant with the standards are issued a corrective action plan (CAP) and are re-educated on the DMHC's appointment availability standards.
   ii. ~~ii~~. Providers, groups, and delegates found non-responsive to the survey are issued a CAP and are re-educated on the DMHC's appointment availability standards.
4) PAAS results, conclusions and recommendations are incorporated into the annual QI Program Evaluation and QI Program Work Plan for the upcoming year. The QI Program Evaluation is reported annually to the Department of Health Care Services (DHCS).
5) The Senior Director of Quality continuously monitors, tracks, and analyzes access and availability rates, continuity of care, and utilization satisfaction indicators to detect incidents, trends, and patterns of dissatisfaction with its provider network. QI staff analyze the data to identify opportunities for improvement with:

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i. ~~i.~~ Systemic operations issues/problems

ii. ~~ii.~~ Complaint types and resolutions; and/or

iii. ~~iii.~~ Member identified needs

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DEFINITIONS / ACRONYMS

Patterns of Non-Compliance means any of the following:

(A) For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers and 80% for NPMH provider follow-up appointments, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific net had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointment (All Provider Survey Types) field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.

(B) The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any ~~of the~~of the following factors in evaluating whether each instance identified is part of noncompliance that is reasonably related:

i. Each instance is a violation of the same standard set forth in subsection (c) of this Rule;

ii. Each instance involves the same network;

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a. Each instance involves the same provider group, or subcontracted plan;

b. Each instance involves the same provider type;

c. Each instance involves the same network provider;

d. Each instance occurs in the same region. For purposes of the subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;

e. The number of enrollees in health plan's network and the total number of instances identified as part of a pattern;

f. Whether each instance occurred within the same twelve-month period; or

g. Whether each instance involves the same category of health care services.

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
QI-104 Potential Quality Issues (PQIs)
QI-105 FSRs MRRs and PARS
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

QI Program Evaluation
QI Work Plan
DMHC PAAS Survey Tools (PCP, Specialist, Psychiatrist, NPMH, Ancillary)

REVISION HISTORY

3/31/2016, 3/9/2017, 3/01/2018, 01/17/2019, 5/16/2019, 3/19/2020, 05/20/2021, 06/28/2022, 03/21/2023 , 6/12/2024

REFERENCES

DMHC PAAS Methodology, Measurement Year 2019
DMHC All Plan Letter 19-008 Timely Access Compliance Reports Measurement Year 2019
APL 24-017 (OPM)

QI-116 Provider Appointment Availability Survey

MONITORING

Any findings and recommendations are reported quarterly to the A&A Committee and to the QIHEC. The Committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The Committees may recommend CAPs be issued by QI staff and Provider Services. Compliance also reviews the PAAS report on an annual basis. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	QI-114
Policy Name	Monitoring of Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	3/6/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") ensures its provider network is sufficient to provide accessibility, availability, and continuity of covered services, per the regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA). The Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegate network.

The Alliance performs ongoing monitoring of its direct and delegate provider network including these provider types:

1. Primary Care Providers (PCPs);
2. Behavioral Health (BH) providers; and
3. Specialists (SPC).

Ongoing monitoring is maintained to ensure network adequacy and address any areas of non-compliance or deficiency related to member's timely access to care and provider availability.

The Alliance will take all necessary steps and appropriate actions to maintain compliance with established Access and Availability standards within its provider network. When non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies.

PROCEDURE

The Alliance Access and Availability (A&A) Committee reviews monitoring reports to determine that:

- provider network geographic distribution,
- provider language capabilities,
- provider capacity levels,
- network adequacy,
- timely appointment availability, and
- provider availability

are compliant with regulatory and accreditation access and availability standards. All monitoring reports and analyses are reviewed at the A&A Committee for evaluation and recommendations of opportunities for improvement.

Access & Availability Reports

Descriptions of the access and availability monitoring reports that are analyzed and reported to the A&A Committee are as follows:

1. Provider Network Capacity

A. Provider Services department staff review network providers whose member assignments are approaching the 2,000:1 capacity ratio of members to PCPs (PRV-003 Provider Network Capacity Standards).

i. Monthly provider capacity reports are developed after the monthly auto-assignment procedures are completed.

a. Providers nearing the 2,000 capacity mark (≥1,900)) are flagged and auto-assignment enrollment is closed.

ii. Provider Services department staff review and track network providers who are at 80% of capacity and above to ensure they do not exceed their capacity threshold.

iii. As appropriate, Provider Services department staff will notify those network providers who are at 80% of capacity and above and will continuously monitor them on a monthly basis. For those network providers who have reached 90% capacity, Provider Services department staff will close them to auto assignment.

iv. For those network providers identified by Provider Services as being below 80% of capacity, Provider Services department staff will remove the flag and enrollment will be reopened to allow the provider to have additional membership assignment up to the 2,000: 1 capacity level.

v. For those network providers found over capacity, Provider Services department staff will reassign their members to another provider and they will be closed to new members.

vi. Those providers will be sent a written notice from Provider Services department staff regarding closed assignment.

vii. QI management will conduct a Quality Access to Care (QOA) audit on all providers who have been identified by Provider Services as having reached the ≥80% member capacity threshold to evaluate the providers access to care compliance. Audit results are reported to the Access and Availability committee to determine if closure of assignment is warranted.

2. Provider Appointment Availability Survey (PAAS)

The Alliance, in conjunction with its Analytics department, annually conducts a Provider Appointment Availability Survey (PAAS) of its PCP, specialty, ancillary, and BH provider network, to ensure provider compliance with the DMHC appointment availability standards, and in accordance with the DMHC PAAS Methodology. Directly contracted providers, as well as the plan's delegated network, are included in the PAAS (QI-116 Provider Appointment Availability Survey).

Based on results of the PAAS, the Alliance Quality Improvement (QI) staff will outreach to providers found to be non-compliant with the standards, as well as non-responsive to the survey. QI staff will inform providers of the survey results, provide re-education on the DMHC appointment availability standards, and issue corrective action plans (CAPs) accordingly. The timely access to care standards are noted in the Provider Directory in the section "Timely Access to Care". In addition, when an ineligible provider is found as a result of PAAS, the respective Alliance Department will send notice to Provider Services team to update the Provider Repository.

3. DHCS First Prenatal Visits (Non-PAAS)

The Alliance, in conjunction with its Analytics department annually conducts a survey of its obstetrics/gynecology (OB/GYN) provider network to ensure provider compliance with the DHCS first prenatal visit standard within 2 weeks of the request. Based on survey results, QI staff will outreach to providers found to be non-compliant with the visit standard, as well as non-responsive to the survey. QI staff will inform providers of the survey results, provide re-education on the DHCS first prenatal visit standard, and issue CAPs accordingly.

Providers who may be excluded from the survey include:

- Hospitalists

4. After-Hours Survey

The Alliance, in conjunction with its QI department and its vendor Press Ganey (PG), at least annually conducts an After-Hours Survey to ensure provider compliance with after-hours (post normal business hours) access and emergency instructions standards, per the DHCS, DMHC, and NCQA regulatory and accreditation requirements. The surveys assess compliance with timely access to a physician or an appropriate licensed professional, as well as with availability of member instructions when experiencing a medical emergency. Based on survey results, QI staff will outreach to providers found to be non-compliant with the after-hours standards, inform them of the survey results, provide re-education on the standards, and issue CAPs accordingly. For those providers identified in the surveys as having potential issues with accurate contact information, QI staff communicate interdepartmentally (Provider Services and Data Analytics to ensure provider information accuracy for future surveys, as well as consider conducting confirmatory surveys as appropriate to ensure provider compliance with the afterhours standards).

Provider types who may be excluded from the After-Hours Survey include:

- Pathologists
- Radiologists
- Emergency Medicine Providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser Providers
- Applied Behavioral Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
- Anesthesiologists

5. Facility Site Reviews (FSRs)

Facility Site Reviews (FSRs) and medical record reviews (MRRs) are conducted on a periodic basis to ensure compliance with the DHCS requirement (Contract, All Plan Letter, and Policy Letter) (QI-105 Primary Care Provider Site Reviews). FSR and MRR evaluations capture provider office compliance with handling missed/broken appointments for diagnostic procedures, lab tests, specialty appointments, and/or other referrals, as well as attempts to contact the member/parent to reschedule appointments. CAPs are issued to providers as needed (refer to escalation process workflows for providers non-responsive to FSR CAPs and for providers non-responsive to critical element CAPs).

6. Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

The Alliance, in conjunction with its vendor PG, as often as quarterly conducts this PCP, Specialist, and BH post-visit survey. The CG-CAHPS measures member experience with health care providers and staff, as well as with in-office wait time, provider time to answer calls during business hours, and provider call return time during business hours. An escalation process for providers identified as non-compliant with CG-CAHPS describes the specific steps taken during the non- compliance periods to ensure appropriate follow up (refer to CG-CAHPS escalation process workflow).

7. High-Volume and High-Impact Specialists

On a quarterly basis, the Alliance reviews the geographic access ratio standards of a subset of specialists identified as high-volume specialists for monitoring of specialist availability within the network (PRV-003 Provider Network Capacity Standards).

Specialists that are reviewed include but are not limited to:

- Cardiologists
- Endocrinologists
- Gastroenterologists
- OB/GYNs
- Psychiatrists

The number of unique members is also identified to determine if access to appointments with high-volume specialists is sufficient for members, per requirement of NCQA.

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Specialists that are reviewed include:

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On a quarterly basis, geographic accessibility reports are reviewed by the Geo Access workgroup (comprised of Provider Services, QI, UM, Operations and Compliance) and used to identify geographic areas potentially lacking access to specific provider types, including, but not limited to, PCPs, specialists, BH providers, hospitals, pharmacies, and ancillary services (PRV-003 Provider Network Capacity Standards).

The A&A Committee will determine whether additional recruitment is needed by particular provider types, or whether the Alliance shall request alternative access standards for areas lacking access. If approved by DHCS, the Alliance will adopt the alternative access standards for the designated area.

9. Access-Related Potential Quality Issues (PQIs)

Upon identification, access-related PQIs (quality of access issues, QOAs) investigated by clinical staff are forwarded to A&A QI staff. A&A Staff will

- Review the QOA issues, check claims data to ensure that the member was not admitted nor went to an Emergency Department. If the member was admitted or went to the ED, the case will be sent to the QI RN Supervisor.
- In addition, the A&A staff member will review MRs if available to ensure that the Member's medical record notes that a longer waiting time will not have a detrimental impact on the health of the Member. MRs may be available through G&A and / or if there is a corresponding QOC case. If this is not properly documented, A&A staff will ensure appropriate provider education.
- Finally, A&A staff will conduct confirmatory surveys calls to provider office to assess timely access compliance. All QOAs requiring confirmatory survey outreach are tracked and trended for compliance performance improvement and issuance of CAPs as warranted.
- For additional information, please see the QOA Workflow. For QOC / QOA cases, the A&A team will randomly select cases on a semi-annual basis to appropriate documentation if a member's appointment was extended. The medical record but document that longer waiting time will not have a detrimental impact on the health of the member. This report will be brought to the A&A Sub-committee for review and appropriate escalation.

10. Extending Member Appointment Timeframe

- On review of the medical records, the record must indicate that:
    - Waiting will not have a detrimental impact of the Member's health as determined by the treating health care provider
    - The provider's decision to extend the applicable waiting time is noted in the Medical Record and is available to DHCS upon request

- The Provider's decision to extend the applicable waiting time must include an explanation of the Member's right to file a Grievance disputing the extension

11. Grievances & Appeals Related to Access

Grievances related to access are reviewed quarterly within Joint Operations Meetings with delegated providers and within the quarterly A&A Committee meetings to identify providers and/or delegates with potential access issues.

A&A QI staff engage in tracking and trending of identified providers/groups/delegates to assess for potential trends in non-compliance within other access-related monitoring reports. If providers/groups/delegates are identified as having a trend of non-compliance with access standards, A&A staff will follow-up with providers and will issue CAPs to address identified deficiencies as appropriate.

12. Provider Language Capacity and Quality of Language (QOL) PQIs Reporting

A. These reports are reviewed quarterly at the Cultural and Linguistic Services (CLS) Committee to inform the Alliance's Provider Services department whether focused contracting efforts are needed for providers who speak languages underrepresented based on the Alliance's Provider Access by Language data report.
B. The Provider Access by Language data report shows a comparison of providers' spoken languages with the demographics of the Alliance's membership.
C. The report also provides needed information for updating the Alliance's Language Assistance Program.
D. Provider language and interpreter capacity is audited annually by the Health Education Department to track and trend and evaluate language access services compared to the prior year.

13. Confirmatory Surveys

Confirmatory surveys are conducted internally and on an ad-hoc basis to assess a random selection of providers against a timely access standard. The selection of providers may include, but is not limited to, the following: those previously issued CAPs; those for whom "spot checks" have been requested; those for whom surveys are indicated subsequent to identification of potentially inaccurate contact information; and others as appropriate. The timely access standards that will be assessed for compliance via these surveys may include, but are not limited to, the following: provider call return time during business hours; provider time to answer call during business hours; urgent, non-urgent and/or first OB/GYN pre-natal provider appointment availability; and after-hours emergency instructions protocol or telephone access to an appropriate licensed professional.

14. Consumer Assessment of Healthcare Providers and Systems 5.1H(CAHPS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed to measure member experience with the health plan and affiliated providers. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

15. Medicare Consumer Assessment of Healthcare Provider and Systems (MCAHPS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to measure members' experiences with obtaining health care and prescription drug coverage. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

16. Medicare Health Outcomes Survey (HOS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to see how well health plan help beneficiaries maintain or improve their health over time. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

17. Timely Access Requirements (TAR) Survey

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey. The survey is designed to obtain enrollees' perspectives and concerns regarding their experiences obtaining timely appointments and interpreter services for health care services. The survey findings are analyzed to identify opportunities to improve members' access to interpreter services.

18. Provider Satisfaction Survey

The Alliance, in conjunction with its vendor PG, conducts an annual provider satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed to measure level of satisfaction with the health plan of Alliance-contracted physicians, non-physician medical providers, and mental health providers. The survey assesses health plan performance in key service areas including all other plans (comparative rating), finance, utilization and quality management, network/coordination of care, pharmacy, call center service, provider relations, overall satisfaction, timely access to health care services for members, and interpreter services.

Provider types who may be excluded from the Provider Satisfaction Survey include:

- Pathologists
- Radiologists
- Emergency Medicine Providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser Providers
- Applied Behavior Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
- Anesthesiologists

Follow-up Actions

Based on qualitative and quantitative analyses of monitoring reports and Quality Committee recommendations, QI staff may engage in any of the following actions:

A. Targeted outreach and marketing campaigns to recruit additional providers and maintain the existing network
B. Negotiations with existing providers to accept additional members and/or to place a hold on assignment of new membership to over-assigned providers
C. Revision of member and provider directories, manuals, and bulletins
D. Tracking and trending of report data to identify best practices and opportunities for improvement
E. Issuing a CAP
F. Education/re-education and outreach (face-to-face, verbal, and/or written) to non-compliant and/or non-responsive providers with a follow-up plan to resurvey within a specified timeframe to assess/reassess compliance with timely access standard(s)
G. Discussions at Joint Operations Meetings (for delegates)
H. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
I. Referral to the Credentialing Committee (CC), and/or to the Peer Review Committee (PRCC) as appropriate, for discussion and recommendations for next steps
J. Other actions as appropriate

Corrective Action Plans (CAPs)

When deficiencies or patterns of non-compliance are found through the monitoring process, the Alliance will issue time-sensitive CAPs to all identified contracted providers and delegates.
The written CAP includes the following:

1. A description of the identified deficiencies
2. The rationale for the CAP

3. The name and telephone number of the QI staff member authorized to respond to provider concerns regarding the CAP issued
4. The due date (within 60 calendar days).
5. For SNC, delegates has six months to correct all deficiencies and action steps that delegates is undertaking to address the CAP.

CAP responses are required to include the following:

1. Corrective action steps providers will take to mitigate the deficiency
2. Supporting documentation demonstrating how the deficiency will be/has been corrected and processes that will be/have been put in place to ensure compliance with regulatory standards and/or contractual requirements
3. Responsible person(s) (name and title) who will address and correct the identified deficiency
4. The target completion date for when the CAP will be completed.

Where CAP responses have been satisfactorily received within the identified timeframe, non-clinical CAPs will be reviewed and closed by A&A management staff within ten (15) business days of receipt of the CAP response. Facility Site Review (FSR) Clinical CAPs will be escalated according to the "Escalation Process for Providers Non-Responsive to Critical Element CAPs."

The Access & Availability Committee will report during each meeting:

- A CAP dashboard showing CAPs issued and closed since the previous Committee meeting
- An update regarding outstanding CAPs that require additional action and/or possible escalation, as appropriate.

DEFINITIONS / ACRONYMS

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

High-Impact Specialist – A type of specialist who treats specific conditions that have serious consequences for the member and require significant resources.

High-Volume Provider - A PCP, a specialist, a provider of ancillary services, or a CBAS provider who has provided a minimum of 500 outpatient visits to 200 unique members, based on total

encounters/claims within the year exclusive of encounter/claims data from CHME, ModivCare, and PerformRx.

PG – Press Ganey.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey (PAAS)
QI-117 Member Satisfaction Survey (CAHPS)
QI-118 Provider Satisfaction Survey
CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
DAT-001 Provider Data and Directories

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Escalation Process for Providers Non-Responsive to Access CAPs
Escalation Process for Providers Non-Responsive to FSR/MRR CAPs
Escalation Process for Providers Non-Responsive to Critical Element CAPs Escalation Process for Providers Non-Compliant with CG-CAHPS

Access-Related PQIs Workflow
After-Hours Survey Tool
After Hours Access Methodology
Provider Appointment Availability Survey Tool
First Prenatal Visit Survey Tool

Facility Site Review Tool Medical Record Review Tool
CG-CAHPS Survey Tool
CAHPS 5.1H Survey Tool
Provider Satisfaction Survey Tool
Alliance Timely Access Standards

REVISION HISTORY

12/17/2015, 11/10/2016, 3/9/2017, 10/17/2017, 3/01/2018, 11/16/2018, 3/21/2019, 5/16/2019, 3/19/2020, 5/20/2021, 6/28/2022, 11/15/2022,11/15/2022,2/17/2022, 3/21/2023, 12/19/2023, 6/12/2024

REFERENCES

QI-114 Monitoring of Access and Availability Standards

DHCS Contract Exhibit A, Attachment 9, Access and Availability DHCS Contract, Exhibit A, Attachment 4-10 and 13

DHCS MMCD All Plan Letters 02-006, 03-006, 03-007, and 15-023

DHCS MMCD Policy Letter 12-006, and 14- 004 Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)

NCQA 2021 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services

DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

MONITORING

The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance network. The A&A Committee reports to the Quality Improvement Health Equity Committee (QIHEC) annually for review and feedback. This policy is reviewed

and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	QI-114
Policy Name	Monitoring of Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	3/6/2024
Administrative Oversight Committee Approval Date	6/12/2024

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B. The Provider Access by Language data report shows a comparison of providers' spoken languages with the demographics of the Alliance's membership.
C. The report also provides needed information for updating the Alliance's Language Assistance Program.
D. Provider language and interpreter capacity is audited annually by the Health Education Department to track and trend and evaluate language access services compared to the prior year.

13. Confirmatory Surveys

Confirmatory surveys are conducted internally and on an ad-hoc basis to assess a random selection of providers against a timely access standard. The selection of providers may include, but is not limited to, the following: those previously issued CAPs; those for whom "spot checks" have been requested; those for whom surveys are indicated subsequent to identification of potentially inaccurate contact information; and others as appropriate. The timely access standards that will be assessed for compliance via these surveys may include, but are not limited to, the following: provider call return time during business hours; provider time to answer call during business hours; urgent, non-urgent and/or first OB/GYN pre-natal provider appointment availability; and after-hours emergency instructions protocol or telephone access to an appropriate licensed professional.

14. Consumer Assessment of Healthcare Providers and Systems 5.1H(CAHPS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed

to measure member experience with the health plan and affiliated providers. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

15. Medicare Consumer Assessment of Healthcare Provider and Systems (MCAHPS)

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The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to measure members' experiences with obtaining health care and prescription drug coverage. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

16. Medicare Health Outcomes Survey (HOS)

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The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to see how well health plan help beneficiaries maintain or improve their health over time. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

17. Timely Access Requirements (TAR) Survey

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The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey. The survey is designed to obtain enrollees' perspectives and concerns regarding their experiences obtaining timely appointments and interpreter services for health care services. The survey findings are analyzed to identify opportunities to improve members' access to interpreter services.

185. Provider Satisfaction Survey

The Alliance, in conjunction with its vendor PG, conducts an annual provider satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed to measure level of satisfaction with the health plan of Alliance-contracted physicians, non-physician medical providers, and mental health providers. The survey assesses health plan performance in key service areas including all other plans (comparative rating), finance, utilization and quality management, network/coordination of care, pharmacy, call center service, provider relations, overall satisfaction, timely access to health care services for members, and interpreter services.

Provider types who may be excluded from the Provider Satisfaction Survey include:

- Pathologists
- Radiologists
- Emergency Medicine Providers
- Physical and Occupational Therapists

- Hearing Aid Dispenser Providers
- Applied Behavior Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
- Anesthesiologists

Follow-up Actions

Based on qualitative and quantitative analyses of monitoring reports and Quality Committee recommendations, QI staff may engage in any of the following actions:

A. Targeted outreach and marketing campaigns to recruit additional providers and maintain the existing network
B. Negotiations with existing providers to accept additional members and/or to place a hold on assignment of new membership to over-assigned providers
C. Revision of member and provider directories, manuals, and bulletins
D. Tracking and trending of report data to identify best practices and opportunities for improvement
E. Issuing a CAP
F. Education/re-education and outreach (face-to-face, verbal, and/or written) to non-compliant and/or non-responsive providers with a follow-up plan to resurvey within a specified timeframe to assess/reassess compliance with timely access standard(s)
G. Discussions at Joint Operations Meetings (for delegates)
H. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
I. Referral to the Credentialing Committee (CC), and/or to the Peer Review Committee (PRCC) as appropriate, for discussion and recommendations for next steps
J. Other actions as appropriate

Corrective Action Plans (CAPs)

When deficiencies or patterns of non-compliance are found through the monitoring process, the Alliance will issue time-sensitive CAPs to all identified contracted providers and delegates.
The written CAP includes the following:

1. A description of the identified deficiencies
2. The rationale for the CAP
3. The name and telephone number of the QI staff member authorized to respond to provider concerns regarding the CAP issued
4. The due date (within 60 calendar days).

5. For SNC, delegates has six months to correct all deficiencies and action steps that delegates is undertaking to address the CAP.

CAP responses are required to include the following:

1. Corrective action steps providers will take to mitigate the deficiency
2. Supporting documentation demonstrating how the deficiency will be/has been corrected and processes that will be/have been put in place to ensure compliance with regulatory standards and/or contractual requirements
3. Responsible person(s) (name and title) who will address and correct the identified deficiency
4. The target completion date for when the CAP will be completed.

Where CAP responses have been satisfactorily received within the identified timeframe, non-clinical CAPs will be reviewed and closed by A&A management staff within ten (15) business days of receipt of the CAP response. Facility Site Review (FSR) Clinical CAPs will be escalated according to the "Escalation Process for Providers Non-Responsive to Critical Element CAPs."

The Access & Availability Committee will report during each meeting:

- A CAP dashboard showing CAPs issued and closed since the previous Committee meeting
- An update regarding outstanding CAPs that require additional action and/or possible escalation, as appropriate.

DEFINITIONS / ACRONYMS

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a provider participating in Medi-Cal managed care.

High-Impact Specialist – A type of specialist who treats specific conditions that have serious consequences for the member and require significant resources.

High-Volume Provider - A PCP, a specialist, a provider of ancillary services, or a CBAS provider who has provided a minimum of 500 outpatient visits to 200 unique members, based on total encounters/claims within the year exclusive of encounter/claims data from ~~Kaiser, Beacon,~~ CHME, ModivCare, and PerformRx.

PG – Press Ganey.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey (PAAS)
QI-117 Member Satisfaction Survey (CAHPS)
QI-118 Provider Satisfaction Survey
CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
DAT-001 Provider Data and Directories

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Escalation Process for Providers Non-Responsive to Access CAPs
Escalation Process for Providers Non-Responsive to FSR/MRR CAPs
Escalation Process for Providers Non-Responsive to Critical Element
CAPs Escalation Process for Providers Non-Compliant with CG-CAHPS

Access-Related PQIs Workflow
After-Hours Survey Tool
After Hours Access Methodology
Provider Appointment Availability Survey Tool
First Prenatal Visit Survey Tool

Facility Site Review Tool Medical Record Review Tool
CG-CAHPS Survey Tool
CAHPS 5.1H Survey Tool
Provider Satisfaction Survey Tool

REVISION HISTORY

12/17/2015, 11/10/2016, 3/9/2017, 10/17/2017, 3/01/2018, 11/16/2018, 3/21/2019, 5/16/2019, 3/19/2020, 5/20/2021, 6/28/2022, 11/15/2022,11/15/2022,2/17/2022, 3/21/2023, 12/19/2023, 6/12/2024

REFERENCES

QI-114 Monitoring of Access and Availability Standards

DHCS Contract Exhibit A, Attachment 9, Access and Availability DHCS Contract, Exhibit A, Attachment 4-10 and 13

DHCS MMCD All Plan Letters 02-006, 03-006, 03-007, and 15-023

DHCS MMCD Policy Letter 12-006, and 14- 004 Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)

NCQA 2021 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services

DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

MONITORING

The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance network. The A&A Committee reports to the Quality Improvement Health Equity Committee (QIHEC) annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	QI –136
Policy Name	Clinical Practice Guidelines
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	Medi-Cal and Group Care
Effective Date	12/19/2023
Committee Name	Quality Improvement Health Equity Committee
Committee Approval Date	
Compliance Committee Approval Date	1

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) adopts, disseminates, and monitors the use of preventive care and other clinical practice guidelines in alignment with DHCS contract requirements. The Alliance adheres to and requires providers to follow the most current preventive care and behavioral health guidelines. The Alliance adopts and reviews other clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances and support Alliance wellness and prevention services.

PROCEDURE

1. Preventive Care Guidelines
   - 1.1. The Alliance requires that all network and delegate providers follow the most current preventive care guidelines.
     - 1.1.1. For adults ages 21 and older, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) clinical preventive services to adults ages 21 and older. All preventive services identified as USPSTF "A" and "B" recommendations must be provided.
     - 1.1.2. For children and adolescents under 21 years old, Alliance providers are required to follow the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule.
     - 1.1.3. The Alliance provides perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).

1.1.4. The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations, regardless of member's age, sex, or medical condition, including pregnancy.

1.1.4.1. Adult vaccines recommended by the U.S. Food and Drug Administration (FDA) and ACIP are covered by the Alliance, without cost sharing

1.1.4.2. Documentation of each member's need for ACIP recommended immunizations is required as part of all regular health visits, including but not limited to illness, care management, or follow up appointments, initial health appointment (IHAs), pharmacy services, prenatal and postpartum care, pre-travel visits, sports, school, or work physicals, visits to a local health department, and well patient check ups

1.1.4.3. All health care providers who administer vaccines must submit patient vaccination records to local health departments and appropriate immunization registries within the specified timelines in accordance with Health and Safety Code (H&S) 120440 and 16 CCR 174.4 (e) as applicable.

1.1.4.4. All immunization records must be reported within 14 calendar days, in accordance with state and federal law.

1.2. Mental and Behavioral Health Guidelines

1.2.1. The Alliance uses the following criteria for provision of Behavioral and Mental Health services: Milliman Clinical Guidelines, CALOCUS, LOCUS, ECSII and the APA Board Guidelines for Autism Spectrum Disorders.

1.3. Alliance providers must document the status of recommended services,

1.4. The Alliance informs providers about required preventive care guidelines through:

1.4.1. Alliance clinical practice guidelines webpage

1.4.2. Quarterly provider communications

1.5. The Alliance monitors the use of required preventive care guidelines through Managed Care Accountability Set (MCAS)/Healthcare Effectiveness Data Information Set (HEDIS) performance, the Facility Site Review and Medical Record Review process, Initial Health Appointment (IHA) rate monitoring and chart audits, or ad hoc chart reviews. See Alliance policy *QI-005 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS) and QI-124 Initial Health Appointment.*

2. Clinical Practice Guidelines

2.1. The Alliance adopts other clinical practice guidelines to support providers and Alliance staff. Adopted guidelines:

2.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field.

2.1.2. Consider the needs of Members.

2.1.3. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines or are developed with involvement of board-certified Providers from appropriate specialties.

2.2. The guidelines are reviewed by the Quality Improvement Medical Director, subcontractors, and other network providers as appropriate. They are approved for adoption by the Internal Quality Improvement Committee (IQIC) and Quality Improvement Health Equity Committee.

2.3. The guidelines are reviewed and updated at least every two years.
2.4. The Alliance distributes the adopted clinical practice guidelines through the Alliance clinical practice guidelines webpage, provider communications, and on request.

DEFINITIONS / ACRONYMS

AAP – American Academy of Pediatrics
ACIP - Advisory Committee on Immunization Practices
ACOG – American College of Obstetrics and Gynecology
CDC - Centers for Disease Control and Prevention
DHCS - California Department of Health Care Services
QIHEC – Quality Improvement Health Equity Committee
IQIC – Internal Quality Improvement Committee
PHM - Population Health Management
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Case Management
Provider Services
Quality Improvement
Claims
Pharamcy

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment (IHA)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

New Policy: 12/19/2023
Revision: 10/8/2024

REFERENCES

DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract
DHCS APL 24-008 Immunization requirements

MONITORING

This Policy will be reviewed annually,

POLICY AND PROCEDURE

Policy Number	QI –136
Policy Name	Clinical Practice Guidelines
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	~~Quality Medical Director~~Senior Director of Quality
Line(s) of Business	Medi-Cal and Group Care
Effective Date	12/19/2023
C~~Subc~~ommittee Name	Quality Improvement Health Equity Committee~~Quali~~
C~~Subc~~ommittee Approval Date	~~11/17/2023~~
Compliance Committee Approval Date	~~2/19/2023~~

POLICY STATEMENT

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2.2 The guidelines are reviewed by the Quality Improvement Medical Director, subcontractors, and other network providers as appropriate. They are approved for adoption by the Internal Quality Improvement Committee (IQIC) and Quality Improvement Health Equity Committee ~~Health Care Quality Committee (HCQC)~~.

2.3 The guidelines are reviewed and updated at least every two years.

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IQIC – Internal Quality Improvement Committee
PHM - Population Health Management
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Case Management
Provider Services
Quality Improvement
Claims
Pharmacy

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment (IHA)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

New Policy: 12/19/2023
Revision: 10/8/2024

REFERENCES

DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract
DHCS APL 24-008 Immunization requirements

MONITORING

This Policy will be reviewed annually

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POLICY AND PROCEDURE

Policy Number	UM-033
Policy Name	Topical Fluoride Varnish
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director of Utilization Management
Lines of Business	Medi-Cal
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

This policy complies with the DHCS directive for the application of topical fluoride varnish (FV) in the medical setting as a Medi-Cal benefit for children under the age of 6 and reimbursable up to 3 times in a 12-month period. When applied to the teeth of infants and young children, the benefit is an evidenced based and effective intervention to prevent dental caries, which is the most common chronic medical problem in children.

Physicians (i.e. primary care physicians), nurses, and medical personnel are legally permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes a protocol. Fluoride varnish applications and oral fluoride supplementation assessment and provision must be consistent with the current Bright Futures/ American Academy of Pediatrics periodicity schedule and anticipatory guidance.

Fluoride varnish is a different form of topical fluoride that is more effective in preventing tooth decay than other forms of topical fluoride, and more practical and safer to use with young children. Fluoride varnish used in accordance with the manufacturer's instructions, is safe for use with infants and young children, and application is fast and easily performed in the medical setting. Fluoride varnish can be swabbed directly onto the teeth in less than 3 minutes and sets within one minute of contact with saliva. The application requires no special dental equipment and can be applied with minimal training by physicians, nurses, and supervised medical assistance.

The Alliance is aware that FV applications may also occur in dental clinics, WIC centers, Head Start centers, and school-based public health outreach efforts. The decision to apply FV should always be based on cavities risk level, and in particular in higher-risk populations such as Medi-Cal/Denti-Cal beneficiaries, three to four or even more applications per year may be needed to obtain optimal effectiveness. A comprehensive review of the Professional Association' recommendations for frequency and Intervals of FV completed by oral health experts from UCSF, the San Francisco Department of Public Health, and the San Francisco State University of Nursing consensus recommends that, children under 6 years old can safely receive FV up to 6 times a year (up to 3 times in dental visits or other settings, and 3 times in medical offices)[1].

The early application of fluoride varnish protects the primary teeth, and ideally should be performed as soon as possible after the teeth first erupt. Providers may purchase fluoride varnish in tubes containing sufficient product for multiple applications; however, many providers find it easier and more convenient to use a prepackaged single use tube, which come with a small disposal applicator brush.

Although dental services are carved out of most managed care contracts, the contract requires managed care plans to cover and ensure access to appropriate dental services. For Members under the age of 21, a dental screening/ oral health assessment is performed as part of every Initial Health Appointment and every periodic assessment, with annual dental referrals to Medi-Cal dental Providers made no later than 12 months of age, or when a referral is indicated based on assessment or acuity and includes the need for dental anesthesia for moderate sedation or deep sedation/ general anesthesia.

PROCEDURE

1. Members are informed of Topical Fluoride Varnish and how to arrange treatment through:
    a. Member Newsletter – annual notice.
    b. Evidence of Coverage (EOC)
2. Compliance, Health Programs, Marketing and Communications collaborate on the above member informing activities.
3. Providers are informed of Topical Fluoride Varnish through the provider bulletin and new provider orientation trainings, and Quality Department HEDIS/ MCAS annual quality efforts and provider outreach. Important points covered are:
    a. How to obtain fluoride varnish supplies – Contact a fluoride varnish supplier or The Alliance's contracted durable medical equipment vendor (CHME) and submit an order to procure fluoride varnish supplies for application in the medical

[1] Berens, L. H., Cholera, M., Elam, D., Fisher-Owens, S. A., Fisher, M., Gansky, S. A., … Zhan, L. (2019). Review of Safety, Frequency and Intervals of Preventive Fluoride Varnish Application for Children. *Journal of the California Dental Association*, *47*(11), 713–718. https://doi.org/10.1080/19424396.2019.12220849

setting.

b. How to obtain fluoride supplements – Contact a local pharmacy and submit a physician prescription.

c. How to do dental assessments and document dental assessment and fluoride varnish in the member's medical record and documenting appropriate CPT codes for this preventive intervention.

d. How to apply the fluoride varnish Trainings:
    i. CHDP Dental Training: Fluoride Varnish at dhcs.gov/services/chdp/Pages/FluorideVarnish
    ii. Joint Alameda Alliance for Health and Alameda County Office of Dental Health trainings and videos completed annually with Providers.

e. When and how to refer children for a dental exam no later than one year of age, and after primary teeth eruption to Medi-Cal dental Providers. The Office of Dental Health updates these providers on their website at minimum yearly.

f. Coordination of dental care with dental professionals according to cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram
    i. Case management referrals for EPSDT (Medi-Cal Kids and Teens) care coordination services through the Alliance health plan.
    ii. Dental care coordination referrals to the Alameda County Office of Dental Health if the Alliance is unable to locate a Medi-Cal dental provider, or for a member who is homeless, is receiving perinatal/ postpartum care, or were lost to established dental care.

g. Encourage and support medical providers to schedule visits that include fluoride varnish application as part of the well-child visits or other medical visit.
    i. 99381: For infants under 1 year old
    ii. 99382: For children ages one to 4 years old
    iii. 99383: For children ages five to 11 years old
    iv. 99391: Periodic comprehensive preventive medicine reevaluation and management of an individual
    v. 99392: Early childhood (age 1 through 4 years old)
    vi. 99393: Late childhood (age 5 through 11 years old)

h. Support appropriate billing and MCAS quality measure capture for fluoride varnish applications in the medical setting: 99188.

4. Medical Services and Provider Services collaborate on the above provider informing activities.

5. Delegation Oversight

a. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

Topical Fluoride Varnish – A lacquer containing 5% sodium fluoride in a colophony/resin base. Fluoride varnish provides a highly concentrated, temporary dose of fluoride to the tooth surface. The varnish holds the fluoride close to the tooth surface for a longer period of time than other fluoride products.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight

QI-101 Quality Improvement and Health Equity Program

QI-135 Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)

UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPST)

UM-024 Care Coordination-Dental Services

RELATED WORKFLOW DOCUMENTS

None

REVISION HISTORY

1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 9/24/24

REFERENCES

AB 667 Topical Fluoride Legislation

Berens, L. H., Cholera, M., Elam, D., Fisher-Owens, S. A., Fisher, M., Gansky, S. A., … Zhan, L. (2019). Review of Safety, Frequency and Intervals of Preventive Fluoride Varnish Application for Children. *Journal of the California Dental Association*, *47*(11), 713–718. https://doi.org/10.1080/19424396.2019.12220849

Bright Futures/ American Academy of Pediatrics

CHDP PM 160 Dental Guide

DHCS APL 21-005: CALAIM Implementation Requirements

DHCS APL 22-030 Initial Health Appointment

DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

DHCS 23-028 Dental Services – Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia Coverage

DHCS Provider Manual – Preventive Services

MMCD Policy Letter 07-008 Topical Fluoride Varnish, California State Department of Health Services, Office of Oral Health – Fluoride Varnish Manual and Guidelines, July 2006

U.S. Preventive Services Task Force (USPSTF), Prevention of dental caries in children from birth through age 5 years.

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

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Policy Number	UM-033
Policy Name	Topical Fluoride Varnish
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director of Utilization Management
Lines of Business	Medi-Cal
Effective Date	1/1/2008
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/18/2023~~TBD

POLICY STATEMENT

This policy complies with the ~~MMCD~~ DHCS directive for the application of topical fluoride varnish (FV) in the medical setting ~~by the Primary Care Provider,~~ as a Medi-Cal benefit for children under the age of 6~~,~~ and reimbursable up to 3 times in a 12-month period. When applied to the teeth of ~~babies~~ infants and young children, the benefit is an evidenced based and effective intervention to prevent dental caries, which is the most common chronic medical problem in ~~young children~~children. ~~For Members under the age of 21, a dental screening/ oral health assessment is performed as part of every periodic assessment, with annual dental referrals made no later than 12 months of age or when referral is indicated based on assessment.~~

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Physicians (i.e. primary care physicians), nurses, and medical personnel are legally ~~p~~permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes a protocol. Fluoride varnish applications and oral fluoride supplementation assessment and provision must be consistent with the current Bright Futures/ American Academy of Pediatrics periodicity schedule and anticipatory guidance.

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Fluoride varnish is a different form of topical fluoride that is more effective in preventing tooth decay than other forms of topical fluoride, and more practical and safer to use with young children. Fluoride varnish used in accordance with the manufacturer's instructions, is safe for use with infants and young children, and application is fast and easily performed in the medical setting. Fluoride varnish can be swabbed directly onto the teeth in less than 3 minutes and sets within one minute of contact with saliva. The application requires no special dental equipment and can be applied with minimal training by physicians, nurses, and supervised medical assistance.

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The Alliance is aware that FV applications may also occur in dental clinics, WIC centers, Head

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Start centers, and school-based public health outreach efforts. The decision to apply FV should always be based on cavities risk level, and in particular in higher-risk populations such as Medi-Cal/Denti-Cal beneficiaries, three to four or even more applications per year may be needed to obtain optimal effectiveness. A comprehensive review of the Professional Association' recommendations for frequency and Intervals of FV completed by oral health experts from UCSF, the San Francisco Department of Public Health, and the San Francisco State University of Nursing consensus recommends that, children under 6 years old can safely receive FV up to 6 times a year (up to 3 times in dental visits or other settings, and 3 times in medical offices)[1].

The early application of fluoride varnish protects the primary teeth, and ideally should be performed as soon as possible after the teeth first erupt. Providers may purchase fluoride varnish in tubes containing sufficient product for multiple applications; however, many providers find it easier and more convenient to use a prepackaged single use tube, which come with a small disposal applicator brush.

Although dental services are carved out of most managed care contracts, the contract requires managed care plans to cover and ensure access to appropriate dental services. For Members under the age of 21, a dental screening/ oral health assessment is performed as part of every Initial Health Appointment and every periodic assessment, with annual dental referrals to Medi-Cal dental Providers made no later than 12 months of age, or when a referral is indicated based on assessment or acuity and includes the need for dental anesthesia for moderate sedation or deep sedation/ general anesthesia.

PROCEDURE

1. Members are informed of Topical Fluoride Varnish and how to arrange treatment through:
    a. Member Newsletter – annual notice.
    b. Evidence of Coverage (EOC)
2. Compliance, Health Programs, Marketing and Communications collaborate on the above member informing activities.
3. Providers are informed of Topical Fluoride Varnish through the provider bulletin and new provider orientation trainings, and Quality Department HEDIS/ MCAS annual quality efforts and provider outreach. Important points covered are:
    a. How to obtain fluoride varnish supplies – Contact a fluoride varnish supplier or Tthe Alliance ~~health plan~~'s contracted durable medical equipment vendor (CHME~~, and~~) and submit an ~~physician~~ order to procure fluoride varnish supplies for application in the medical setting.
    ~~b.~~ How to obtain fluoride supplements – Contact a local pharmacy and submit a physician prescription.
    b.
    c. How to do dental assessments and document dental assessment and fluoride

[1] Berens, L. H., Cholera, M., Elam, D., Fisher-Owens, S. A., Fisher, M., Gansky, S. A., … Zhan, L. (2019). Review of Safety, Frequency and Intervals of Preventive Fluoride Varnish Application for Children. *Journal of the California Dental Association*, *47*(11), 713–718. https://doi.org/10.1080/19424396.2019.12220849

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varnish in the member's medical ~~record~~record and documenting appropriate CPT codes for this preventive intervention. ~~or on the CHDP form PM 160 (until the CHDP form is formally retired).~~

d. How to apply the fluoride varnish Trainings:
   - i. CHDP Dental Training: Fluoride Varnish at dhcs.gov/services/chdp/Pages/FluorideVarnish
   - ii. Joint Alameda Alliance for Health and Alameda County Office of Dental Health trainings and videos completed annually with Providers. ~~.~~

e. When and how to refer children for a dental exam no later than one year of age, and after primary teeth eruption to Medi-Cal dental Providers. The Office of Dental Health updates these providers on their website at minimum yearly.

f. Coordination of dental care with dental professionals according to cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram
   - i. Case management referrals for EPSDT (Medi-Cal Kids and Teens) care coordination services through the Alliance health plan.
   - ii. Dental care coordination referrals to the Alameda County Office of Dental Health if the Alliance is unable to locate a Medi-Cal dental provider, or for a member who is homeless, is receiving perinatal/postpartum care, or were lost to established dental care. ~~.~~

g. Encourage and support medical providers to schedule visits that include fluoride varnish application as part of the well-child visits or other medical ~~setting.~~visit.
   - i. 99381: For infants under 1 year old
   - ii. 99382: For children ages one to 4 years old
   - iii. 99383: For children ages five to 11 years old
   - iv. 99391: Periodic comprehensive preventive medicine reevaluation and management of an individual
   - v. 99392: Early childhood (age 1 through 4 years old)
   - ~~i.~~vi. 99393: Late childhood (age 5 through 11 years old)

~~g.~~h. Support a~~A~~ppropriate billing and ~~for~~ MCAS quality measure capture for fluoride varnish applications in the medical setting~~s~~: 99188. ~~.~~

4. Medical Services and Provider Services collaborate on the above provider informing activities.

5. Delegation Oversight

   a. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

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Topical Fluoride Varnish – A lacquer containing 5% sodium fluoride in a colophony/resin base. Fluoride varnish provides a highly concentrated, temporary dose of fluoride to the tooth surface. The varnish holds the fluoride close to the tooth surface for a longer period of time than other fluoride products.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight

QI-101 Quality Improvement and Health Equity Program

QI-135 Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)

UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPST)

UM-024 Care Coordination-Dental Services

RELATED WORKFLOW DOCUMENTS

None

REVISION HISTORY

1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 9/24/24

REFERENCES

AB 667 Topical Fluoride Legislation

Berens, L. H., Cholera, M., Elam, D., Fisher-Owens, S. A., Fisher, M., Gansky, S. A., … Zhan, L. (2019). Review of Safety, Frequency and Intervals of Preventive Fluoride Varnish Application for Children. *Journal of the California Dental Association*, *47*(11), 713–718. https://doi.org/10.1080/19424396.2019.12220849

Bright Futures/ American Academy of Pediatrics

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~~APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic and Treatment services for Medi-Cal Members Under the age of 21~~

CHDP PM 160 Dental Guide

DHCS APL 21-005: CALAIM Implementation Requirements

~~Bright Futures/ American Academy of Pediatrics~~

DHCS APL 22-030 Initial Health Appointment

DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

DHCS 23-028 Dental Services – Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia Coverage

DHCS Provider Manual – Preventive Services

MMCD Policy Letter 07-008 Topical Fluoride Varnish, California State Department of Health Services, Office of Oral Health – Fluoride Varnish Manual and Guidelines, July 2006

~~CHDP PM 160 Dental Guide~~

U.S. Preventive Services Task Force (USPSTF), Prevention of dental caries in children from birth through age 5 years.

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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

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POLICY AND PROCEDURE

Policy Number	UM-003
Policy Name	Concurrent Review and Discharge Planning Process
Department Name	Health Care Services
Policy Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

Admission Review: Admissions to the acute hospital / long-term care acute hospital (LTACH)/ inpatient behavioral, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Sub-acute facility (peds and adults), SNF, acute Rehabilitation facility, etc.) for elective or non-elective diagnostic or therapeutic reasons must meet the guidelines for admission, utilizing approved written criteria, whether or not the admission was prior approved.

Continuous Stay Review: Subsequent review for ongoing medical necessity. Continued stay, (timeframe dependent upon the diagnosis and the progress of the patient) review will be performed using written criteria for medical necessity/continuous care and must be met to be approved.

PROCEDURE

A. Admission Review

1. The contracted Hospitals/ facilities will fax a copy of the admission face sheet for any new admissions to the health plan within 24 hours of the admission.
    a. Elective admissions will have a tracking number and pre-certification referral on file.

b. Emergent admissions will require new case creation.

2. All facilities, contracted and non-contracted, must notify the Alliance within 24 hours of a change in the level of care or discharge from facility.
    a. Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.
    b. Notifications and clinical notes received outside of the above timeframes may result in a delay/ deferral, or denial of the authorization for service and payment.
3. The timeliness of the admission review is based on the member's line of business:
    a. Medi-Cal: reviewed within 24 hours of receipt of the request.
    b. Group Care: reviewed within 24 hours of admission, even during non-business operating days. This ensures compliance with 45 CFR § 146.136 for the Mental Health Parity and Addiction Equity Act (MHPAEA) that requires the same standards applied for medical/surgical and mental health and/or substance abuse disorder benefits. This includes the standards for the UM authorization process and criteria applied for medical necessity review.
4. Eligibility and member's delegate assignment will be verified.
5. Authorization number will be assigned by the data system.
6. The review process may include, but not be limited to, the following:
    a. Chart review;
    b. Data collection;
    c. Application of evidenced based criteria to determine the medical necessity of admission
    d. Review of care plans; and/or
    e. Transition of care services (TCS), social determinants of health (SDOH), and discharge planning
7. Complex and/or catastrophic cases will be discussed with the Medical Director or Director of Utilization Management.
8. The Medical Director may consult with the admitting physician on questions of medical necessity.
    a. If the Medical Director/ designee, following that consultation, determines the hospitalization is inappropriate, an alternative plan will be discussed with the admitting physician and a patient discharge will be requested.
    b. Inpatient care will be continued until the treating physician is notified and agrees on an appropriate care plan.
    c. Notifications will be made according to established regulatory requirements if the admission does not meet medical necessity criteria. (See most recent versions of DHCS Notice of Action Templates or Commercial – IHSS UM Determination Templates)
    d. Only a Medical Director/ designee or doctoral Behavioral Health Practitioner may make a decision to deny services when medical necessity criteria are not met.

B. Medical Concurrent Review

1. Concurrent review is performed applying written criteria to determine medical

necessity on a daily basis or on the cadence indicated in the criteria guidelines or based on the member's clinical condition:

a. Two (2) to five (5) days a week, as appropriate for medical care review.

b. Not more than two (2) days per week for mental health and substance use admissions.

c. The patient is followed through the continuum/ levels of care, until they have returned to the optimum level of functioning.

d. Inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care or next level of care, Utilization Management staff will continue to perform continued stay reviews. The minimum review frequency is every 1 week or when the member's condition changes, until the Member is safely transitioned to the next level of care. Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services. See UM Policy UM-052.

2. Concurrent review information is obtained either via telephonic review, review of Electronic Health Record , by the portal or by fax, by a UM Clinical Reviewer.

   a. Select Medical Groups/ IPAs are delegated to perform concurrent review of assigned members applying written criteria, at the appropriate clinical cadence while hospitalized.

   b. The health plan and Medical Group/ IPA UM Department coordinate with each other, as appropriate.

3. Documentation is entered in the plan's database:

   a. Member progress is documented in a clinical note in the plan's database.

   b. The review cycle is continued at the appropriate clinical cadence until discharge.

   c. Documentation includes the date, time, and condition upon patients' discharge.

4. Following review, if the Medical Director determines the patient does not meet the medical necessity criteria for the current level of care and could be safely discharged or transferred to a lower level of care:

   a. The Reviewer will assess if adequate discharge efforts were made by the current facility, and if there is evidence of an unsafe discharge plan in place for the member (see UM-052).

   b. Only a Medical Director or designee/doctoral Behavioral Health Practitioner may make a decision to deny services.

   c. Qualified Medical Directors or designees review all denials of continued acute and long-term acute care hospitals (LTACH), Subacute, ICF-DD, Skilled Nursing Facility, and acute Rehabilitation facilities, services throughout the members' hospital stays.

C. Notice of Action Letters

1. For admissions that do not meet ongoing medical necessity for initial admission or continued stay, Medi-Cal members and providers are sent a Notice of Action (NOA) letter, for the initial denial and at every subsequent review. See UM-054 Notice of Action and UM-057 Authorization Request, for details on decision notification content and appeal rights.

a. All other lines of business – send standard denial NOA letter if coverage is being discontinued.

2. The UM Staff responsible for letters will follow the Standard Review procedures which includes the requirement that members and providers are given a NOA letter with accurate information about the denied date(s) and the requesting providers.

3. UM Staff will generate NOAs in the UM Information System, TruCare, which is configured to display the correct dates and providers in the automated portion of the NOA letters.

4. Prior to final issuing of NOAs, UM staff will verify the dates, service request/ stay level on the NOA match the dates of the final determination.

   a. NOAs found with discrepancies are immediately brought to the attention of UM Management team for immediate intervention.

D. Discharge Planning for All Lines of Business

1. Discharge planning and transitions of care services (TCS) begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment as applicable.

   a. The discharge plan will be coordinated with the attending physician, the member and/or family, the hospital staff, the identified TCS care manager and any appropriate home health agencies/ vendors (i.e., home health, DME vendors, infusion services, etc.) or transportation needs.

   b. The need for patient education will be assessed as part of the Discharge Planning process.

   c. Evaluation of the discharge plan is included in the concurrent review sessions between the UM Clinical Reviewer, the Medical Director and facility's discharge planning staff.

      1). The member will be evaluated for potential alternative care needs.

      2). The attending physician will be responsible for keeping the member and family informed of progress toward discharge or transition to an alternative level of care.

      3). Notification of transition to an alternative level of care:

         i). Medi-Cal members and providers are sent a Notice of Action (NOA) letter.

         ii). All other lines of business – send standard denial letter if coverage is being changed/discontinued.

   d. Based on the discharge plan, the UM Clinical Reviewer will verify benefits for services and provide contracted vendor information and issue an authorization number to the Hospital Case Manager, as appropriate.

   e. Non-clinical staff may administratively enter limited visit authorizations for Home Health follow-up when a Home Health order is in place and an accepting provider has been identified.

   f. The UM Clinical Reviewer will coordinate the notification of the appropriate vendor regarding the discharge plan, date of discharge, and provide the authorization number.

g. The UM Clinical Reviewer will apprise the appropriate TCS Care Manager, of the discharge for the purpose of scheduling follow-up care, as needed.

h. For discharge to a lower level of care facility:

1). The discharge plan will be coordinated with the attending physician, the member and/or family member or designated decision maker, and the hospital interdisciplinary staff. Evaluation of the discharge plan is included in the concurrent review process with the AAH UM Nurse/Reviewer, the facility discharge planning staff, the identified TCS Care Manager and the AAH Medical Director as indicated.

2). The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

i). When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs.

- The AAH UM staff will assist in contacting potential accepting facilities.
- The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.
- The case will be discussed at Extended Length of Stay Rounds to identify placement options.
- If LOS is prolonged, the AAH UM staff will escalate the case to AAH clinical and operational leadership to develop strategies to locate appropriate placement. See UM-052
    - Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

E. Discharge Planning and Care Coordination, including for SPD Members

1. Discharge planning covers the period from admission to a hospital or institution and continues into the post-discharge period and ensures:

a. Necessary care, services and supports are in place in the community after discharge.

b. Outpatient appointments and/or follow-up visits with the member and/or caregiver are scheduled.

c. Placement in lower level of care facilities is a coordinated transition of care.

d. All discharge planning applies to in-network providers/ facilities or out of network (OON) providers/ facilities if needed to meet the needs of the members.

e. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.

2. Discharge planning is:

a. Conducted through collaboration between the hospital/institution discharge planning staff and the Alliance UM Clinical Reviewer and the identified TCS Care Manager.

b. Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
   1). Re-institutionalization,
   2). Re-hospitalization,
   3). Destabilization of a mental health condition,
   4). And/or SUD relapse.

c. Documented in both the hospital's patient medical record and/or the Alliance's member database and includes the following elements:
   1). Pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received.
   2). Pre-discharge factors including an understanding of the medical condition by the member/representative as applicable, physical and mental function, financial resources, and other social determinants of health, and social supports.
   3). Services needed after discharge to include:
      i). Type of placement preferred and agreed to by the member/ family representative or designated decision maker.
      ii). Specific agency/ home recommended by the hospital and agreed to by the member/representative or designated decision maker.
      iii). Eligibility for ongoing care management services such as ECM, Complex CM, or other community case management services.
      iv). Recommended pre-discharge counseling.
   4). Summary of the nature and outcome of:
      i). Member/ representative or designated decision maker, involvement in the discharge planning process
      ii). Anticipated problems in implementing post-discharge plans
      iii). Further action contemplated by the hospital/institution.

F. Behavioral Health Concurrent Review Process

1. Concurrent review is conducted for mental health and substance use disorder inpatient admissions. For behavioral health care, concurrent reviews for inpatients occur no more than three (3) days per week and not less than every 2 weeks. For residential treatment,

reviews occur monthly.

2. Medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), and World Professional Association for Transgender Health (WPATH).

3. Concurrent review processes for behavioral health follow the same information gathering, documentation, medical review and notice of action (NOA) processes as described in this policy for medical services.

4. G. **Inpatient Behavioral Health Discharge Planning Coordination**

a. The discharge plan is reviewed for appropriateness, based on the individual's needs, and may include the following:
b. The discharge plan is realistic, comprehensive, timely and concrete;
c. The plan takes into consideration the AAH BH Clinician's recommendations and member's preferences, as recorded in previous treatment review notes;
d. Transition from one level of care or program to another is coordinated, and involves coordination with ACBHCS for Medi-Cal members with SMI/SUD;
e. AAH incorporates actions to assure continuity of existing therapeutic relationships, as appropriate;
f. The provider assists the member, parent, or guardian to understand the status of the discharge plan and has a signed copy;
g. Transportation and other needs are addressed as applicable;
h. The discharge plan is communicated to the aftercare provider(s) as applicable and with the member's permission;
i. Psychopharmacological needs are addressed;
j. Medical condition(s) follow-up needs are addressed.
k. Collaboration with medical practitioner has occurred, as necessary;
l. The member has timely access to the recommended aftercare services including date of first appointment, with whom, where, and other treatment and community resources to be utilized;
m. Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
n. Support systems are outlined;
o. Community services and/or self-help groups are recommended;
p. Linkages to EAP services are established as appropriate;
q. Family/Work/Community preparation has occurred which supports reintegration as appropriate.
r. Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning.

G. Transitional Care Services

1. The UM Clinical Reviewer will make referrals to Case/Disease Management and/or the Behavioral Health staff as appropriate, to provide Transitional Care Services at the beginning of the stay to ensure that a safe and appropriate transition plan is enacted for

the member.

a. Transitional Care Services (TCS) includes:

- Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
- Discharge Risk Assessment
  - Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
    - re-institutionalization,
    - re-hospitalization,
    - destabilization of a mental health condition,
    - and/or SUD relapse.
- Discharge Planning document.
- A full description of the Alliance TCS program is found in CM-034 Transition of Care policy.

2. The member's needs are identified based on the following:
   a. Social environment
   b. Support structure through family and friends
   c. Availability and accessibility of needed services
   d. General Safety
   e. Complete care of the member on a continuum, including mental health and substance abuse services.

H. <u>Post- Acute care Admission to Hospice</u>:

a. Hospice services will be provided to any member who receives a physician's certification that the member has a terminal illness and who elects hospice services.

b. Covered hospice services will be made available in a timely manner, preferably within 24 hours of the request.

c. Only general inpatient hospice services are subject to prior authorization (PA). PA is not a Medi-Cal requirement for routine home care, continuous home care, or hospice respite care.

d. The following settings are considered appropriate for post-acute care admission into Hospice:

i. The member's home;
ii. A distinct part of a hospital psychiatric or rehabilitation unit;
iii. A home-based community setting; or
iv. A transition into the home.

I. Admission to Out of Network (OON) or Out of Area Facilities

1. Emergency admission to an OON or Out of Area facility will be followed by the UM or Behavioral Health (BH) Department. The UM/BH Clinical Reviewer will follow

the member, utilizing the above guidelines, until the member is able to be safely transferred back into the appropriate network. The LOA process will be enacted for the Out of Network facility as needed or invited to contract with AAH.

2. The UM/BH Department will collaborate on a plan of care for a member who is being prior-authorized for out-of-area/network care. This includes referral to the TCS program to ensure that the safe and appropriate discharge plan and follow up care is enacted. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
3. The Member Services department will be notified if it appears that the member has moved permanently out of the area.

J. Coordination with Behavioral Health

1. Admissions related to behavioral health conditions are managed by the behavioral health staff and in compliance with the regulatory requirements and most recent DHCS All Plan Letter related to Medi-Cal Managed Care Health Plan Responsibilities for Mental Health Services.
2. Behavioral health admissions are co-managed when necessary to ensure the collaboration of medical and behavioral health services. AAH will facilitate access to necessary medical information and services for transition or discharge planning.
3. Members identified with need for medical case management services will be referred as defined in CM policy.

L. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS AND ACRONYMS

Concurrent request – A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Discharge Planning – The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and potentially other health professionals; its goal is to enhance continuity of care. It begins on admission.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

BH-001 Behavioral Health Services
CM-001 Complex Case Management Identification, Screening Assessment and Triage
CMP-019 Delegation Oversight
UM-001 Utilization Management Program UM-051 Timeliness of UM Decision Making
UM-052 Discharge Planning to Lower Level of Care, Including Granting Administrative Days

Pending Placement for Facilities contracted for Administrative Days
UM-054 Notice of Action
UM-057 Authorization Request UM-060 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/21/2006, 1/1/2008, 1/16/2009, 4/13/2011, 9/7/2012, 7/13/2013, 3/14/2014, 12/9/2016, 12/15/2016, 4/12/2018, 04/15/2019, 09/19/2019, 1/21/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023, 7/17/2024, 8/26/2024

REFERENCES

1. 45 CFR §146.136 Mental Health Parity and Addiction Equity Act
2. DHCS Contract, Exhibit A, Attachment 5, Provisions 2 and 3
3. DHCS PHM Policy Guide May 2024
4. DHCS PHM FAQ June 2024
5. Title 42, CFR, Sections 422.118 and 422.620

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee and Administrative Oversight Committee.

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-003
Policy Name	Concurrent Review and Discharge Planning Process
Department Name	Health Care Services
~~**Department Officer**~~	~~Chief Medical Officer~~
~~**Department** **Policy** **Owner**~~	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	~~7/17/2024~~TBD

POLICY STATEMENT

This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

Admission Review: Admissions to the acute hospital / long-term care acute hospital (LTACH)/ inpatient behavioral, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ~~or~~ Ssub-acute facility (peds and adults), ~~(i.e., SNF~~ SNF, acute ,~~-~~Rehabilitation facility, etc.) for e~~E~~lective or n~~N~~on-elective diagnostic or therapeutic reasons must meet the guidelines for admission, utilizing approved written criteria, whether or not the admission was prior approved.

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Continuous Stay Review: S~~s~~ubsequent review for ongoing medical necessity. Continued stay, (timeframe dependent upon the diagnosis and the progress of the patient) review will be performed using written criteria for medical necessity/continuous care and must be met to be approved.

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PROCEDURE

A. Admission Review

1. The contracted Hospitals/ facilities will fax a copy of the admission face sheet for any new admissions to the health plan within 24 hours of the admission.

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   a. Elective admissions will have a tracking number and pre-certification referral on

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file.

b. Emergent admissions will require new case creation.

2. All facilities, contracted and non-contracted, must notify the Alliance within 24 hours of a change in the level of care or discharge from facility.
    a. Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.
    b. Notifications and clinical notes received outside of the above timeframes may result in a delay/ deferral, or denial of the authorization for service and payment.
3. The timeliness of the admission review is based on the member's line of business:
    a. Medi-Cal: reviewed within 24 hours of receipt of the request.
    b. Group Care: reviewed within 24 hours of admission, even during non-business operating days. This ensures compliance with 45 CFR § 146.136 for the Mental Health Parity and Addiction Equity Act (MHPAEA) that requires the same standards applied for medical/surgical and mental health and/or substance abuse disorder benefits. This includes the standards for the UM authorization process and criteria applied for medical necessity review.
4. Eligibility and member's delegate assignment will be verified.
5. Authorization number will be assigned by the data system.
6. The review process may include, but not be limited to, the following:
    a. Chart review;
    b. Data collection;
    c. Application of ~~written~~ evidenced based criteria to determine the medical necessity of admission~~.~~
    d. Review of care plans; and/or
    e. Transition of care services (TCS), social determinants of health (SDOH), and discharge planning
7. Complex and/or catastrophic cases will be discussed with the Medical Director or Director of Utilization Management.
8. The Medical Director ~~will~~ may consult with the admitting ~~practitioner~~ physician on questions of medical necessity.
    a. If the Medical Director/ designee, following that consultation, determines the hospitalization is inappropriate, an alternative plan will be discussed with the admitting ~~practitioner~~ physician and a patient discharge will be requested.
    b. Inpatient care will be continued until the treating ~~practitioner~~ physician is notified and agrees on an appropriate care plan.
    c. Notifications will be made according to established regulatory requirements if the admission does not meet medical necessity criteria. (See most recent versions of DHCS Notic~~S~~e of Action Templates or Commercial – IHSS UM Determination Templates)
    d. Only a ~~physician~~Medical Director/ designee or ~~/~~doctoral Behavioral Health Practitioner may make a decision to deny services when medical necessity criteria are not met.

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B. Medical Concurrent Review

1. Concurrent review is performed applying written criteria to determine medical necessity on a daily basis or on the cadence indicated in the criteria guidelines or ~~by~~ based on the member's clinical condition:
   a. Two (2) to five (5) days a week, as appropriate for medical care review.
   b. Not more than two (2) days per week for mental health and substance use admissions.
   c. The patient is followed through the continuum/ levels of care, until they have returned to the optimum level of functioning.
   ~~c.~~
   d. Inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care or next level of care, Utilization Management staff will continue to perform continued stay reviews. The minimum review frequency is every 12 week~~s~~ or when the member's condition changes, until the Member is safely transitioned to the next level of care. Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services. See UM Policy UM-052.
2. Concurrent review information is obtained either via telephonic review, review of Electronic Health Record, by the portal or by ~~facsimile~~fax, ~~or onsite review~~ by a UM Clinical Reviewer.
   a. Select Medical Groups/ IPAs are delegated to perform concurrent review of assigned members applying written criteria, at the appropriate clinical cadence while hospitalized.
   b. The health plan and Medical Group/ IPA UM Department coordinate with each other, as appropriate.
3. Documentation is entered in the plan's database:
   a. Member progress is documented in a clinical note in the plan's database.
   b. The review cycle is continued at the appropriate clinical cadence until discharge.
   c. Documentation includes the date, time, and condition upon patients' discharge.
4. Following review, if the Medical Director determines the patient does not meet the medical necessity criteria for the current level of care and could be safely discharged or transferred to a lower level of care:
   a. The Reviewer will assess if adequate discharge efforts were made by the current facility, and if there is evidence of an unsafe discharge plan in place for the member (see UM-052).
   ~~a.~~b. Only a Medical Director or designee~~physician~~/doctoral Behavioral Health Practitioner may make a decision to deny services.
   ~~b.~~c. Qualified ~~physicians~~ Medical Directors or designees review all denials of continued acute and long-term acute care hospitals (LTACH), Subacute, ICF-DD, Skilled Nursing Facility, and acute Rehabilitation facilities, services throughout the members' hospital stays.

C. Notice of Action Letters

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1. For admissions that do not meet ongoing medical necessity for initial admission or continued stay, Medi-Cal members and providers are sent a Notice of Action (NOA) letter, for the initial denial and at every subsequent review. See UM-054 Notice of Action and UM-057 Authorization Request, for details on decision notification content and appeal rights.
    a. All other lines of business – send standard denial NOA letter if coverage is being discontinued.
2. The UM Staff responsible for letters will follow the Standard Review procedures which includes the requirement that members and providers are given a NOA letter with accurate information about the denied date(s) and the requesting providers.
3. UM Staff will generate NOAs in the UM Information System, TruCare, which is configured to display the correct dates and providers in the automated portion of the NOA letters.
4. Prior to final issuing of NOAs, UM staff will verify the dates, service request/ stay level on the NOA match the dates of the final determination.
    a. NOAs found with discrepancies are immediately brought to the attention of UM Management team for immediate intervention.

D. Discharge Planning for All Lines of Business

1. Discharge planning and transitions of care services (TCS) begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment as applicable.
    a. The discharge plan will be coordinated with the attending physician, the member and/or family, the hospital staff, the identified TCS care manager and any appropriate home health agencies/ vendors (i.e., home health, DME vendors, infusion services, etc.) or transportation needs.
    b. The need for patient education will be assessed as part of the Discharge Planning process.
    c. Evaluation of the discharge plan is included in the concurrent review sessions between the UM Clinical Reviewer, the Medical Director and facility's discharge planning staff.
        1). The member will be evaluated for potential alternative care needs.
        2). The attending physician will be responsible for keeping the member and family informed of progress toward discharge or transition to an alternative level of care.
        3). Notification of transition to an alternative level of care:
            i). Medi-Cal members and providers are sent a Notice of Action (NOA) letter.
            ii). All other lines of business – send standard denial letter if coverage is being changed/discontinued.
    d. Based on the discharge plan, the UM Clinical Reviewer will verify benefits for services and provide contracted vendor information and issue an authorization number to the Hospital Case Manager, as appropriate.
    e. Non-clinical staff may administratively enter limited visit authorizations for Home

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Health follow- up when a Home Health order is in place and an accepting provider has been identified.

f. The UM Clinical Reviewer will coordinate the notification of the appropriate vendor regarding the discharge plan, date of discharge, and provide the authorization number.

g. The UM Clinical Reviewer will apprise the appropriate ~~Primary Care Physician (PCP) and/or mental health provider, identified~~ TCS Care Manager, ~~when appropriate,~~ of the discharge ~~instructions~~ for the purpose of scheduling follow-up care, as needed.

h. For discharge to a lower level of care facility:

1). The discharge plan will be coordinated with the attending physician, the member and/or family member or designated decision maker, and the hospital interdisciplinary staff. Evaluation of the discharge plan is included in the concurrent review process with the AAH UM Nurse/Reviewer, the facility discharge planning staff, the identified TCS Care Manager and the AAH Medical Director as indicated.

2). The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

i). When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs.

- The AAH UM staff will assist in contacting potential accepting facilities.
- The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.
- The case will be discussed at Extended Length of Stay Rounds to identify placement options.
- If LOS is prolonged, the AAH UM staff will escalate the case to AAH clinical ~~and/or~~and operational leadership to develop strategies to locate appropriate placement. See UM-052
    - Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

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E. Discharge Planning and Care Coordination, including for SPD Members

1. Discharge planning covers the period from admission to a hospital or institution and continues into the post-discharge period and ensures:
   a. Necessary care, services and supports are in place in the community after discharge.
   b. Outpatient appointments and/or follow-up visits with the member and/or caregiver are scheduled.
   c. Placement in lower level of care facilities is a coordinated transition of care.
   d. All discharge planning applies to in-network providers/ facilities or out of network (OON) providers/ facilities if needed to meet the needs of the members.
   e. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
2. Discharge planning is:
   a. Conducted through collaboration between the hospital/institution discharge planning staff and the Alliance UM Clinical Reviewer and the identified TCS Care Manager.
   b. Based on the DHCS PHM Policy Guide~~-~~ the MCP must have oversight of the Hospital's discharge planning process to ensure they ~~a standardized Discharge Risk Assessment that is completed by either the discharging facility staff or AAH/Delegate staff prior to discharge to~~ assess, at minimum, a member's risk of:
      1). Re-institutionalization,
      2). Re-hospitalization,
      3). Destabilization of a mental health condition,
      4). And/or SUD relapse.
   c. Documented in both the hospital's patient medical record and/or the Alliance's member database and includes the following elements:
      1). Pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received.
      2). Pre-discharge factors including an understanding of the medical condition by the member/representative as applicable, physical and mental function, financial resources, and other social determinants of health, and social supports.
      3). Services needed after discharge to include:
         i). Type of placement preferred and agreed to by the member/ family representative or designated decision maker.
         ii). Specific agency/ home recommended by the hospital and agreed to by the member/representative or designated decision maker.~~.~~
         iii). Eligibility for ongoing care management services such as ECM, Complex CM, or other community case management services.
         iv). Recommended pre-discharge counseling.
      4). Summary of the nature and outcome of:

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~~i).~~ Member/ representative or designated decision maker, involvement in the discharge planning process

i). ~~process~~

ii). Anticipated problems in implementing post-discharge plans

~~ii).~~iii). ~~iii).~~ Further action contemplated by the hospital/institution.

F. Behavioral Health Concurrent Review Process

1. Concurrent review is conducted for mental health and substance use disorder inpatient admissions. For behavioral health care, concurrent reviews for inpatients occur no more than three (3) days per week and not less than every 2 weeks. For residential treatment, reviews occur monthly.

2. Medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), and World Professional Association for Transgender Health (WPATH).

3. Concurrent review processes for behavioral health follow the same information gathering, documentation, medical review and notice of action (NOA) processes as described in this policy for medical services.

~~F.~~4. G. **Inpatient Behavioral Health Discharge Planning Coordination**

a. The discharge plan is reviewed for appropriateness, based on the individual's needs, and may include the following:
b. The discharge plan is realistic, comprehensive, timely and concrete;
c. The plan takes into consideration the AAH BH Clinician's recommendations and member's preferences, as recorded in previous treatment review notes;
d. Transition from one level of care or program to another is coordinated, and involves coordination with ACBHCS for Medi-Cal members with SMI/SUD;
e. AAH incorporates actions to assure continuity of existing therapeutic relationships, as appropriate;
f. The provider assists the member, parent, or guardian to understand the status of the discharge plan and has a signed copy;
g. Transportation and other needs are addressed as applicable;
h. The discharge plan is communicated to the aftercare provider(s) as applicable and with the member's permission;
i. Psychopharmacological needs are addressed;
j. Medical condition(s) follow-up needs are addressed.
k. Collaboration with medical practitioner has occurred, as necessary;
l. The member has timely access to the recommended aftercare services including date of first appointment, with whom, where, and other treatment and community resources to be utilized;
m. Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
n. Support systems are outlined;
o. Community services and/or self-help groups are recommended;

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p. Linkages to EAP services are established as appropriate;
q. Family/Work/Community preparation has occurred which supports reintegration as appropriate.
r. Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning.

G. Transitional Care Services

1. The UM Clinical Reviewer will make referrals to Case/Disease Management and/or the Behavioral Health staff as appropriate, to provide Transitional Care Services at the beginning of the stay to ensure that a safe and appropriate transition plan is enacted for the member.
   a. Transitional Care Services (TCS) includes:
      - Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
      - Discharge Risk Assessment
        - Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
        - ~~A standardized Discharge Risk Assessment is completed by either the discharging facility staff or AAH/Delegate staff prior to discharge to assess, at minimum, a member's risk of:~~
          - re-institutionalization,
          - re-hospitalization,
          - destabilization of a mental health condition,
          - and/or SUD relapse.
      - Discharge Planning document.
      - A full description of the Alliance TCS program is found in CM-034 Transition of Care policy.
2. The member's needs are identified based on the following:
   a. Social environment
   b. Support structure through family and friends
   c. Availability and accessibility of needed services
   d. General Safety
   e. Complete care of the member on a continuum, including mental health and substance abuse services.

H. <u>Post- Acute care Admission to Hospice</u>:

a. Hospice services will be provided to any member who receives a physician's certification that the member has a terminal illness and who elects hospice services.
b. Covered hospice services will be made available in a timely manner, preferably within 24 hours of the request.

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c. Only general inpatient hospice services are subject to prior authorization (PA). PA is not a Medi-Cal requirement for routine home care, continuous home care, or hospice respite care.

d. The following settings are considered appropriate for post-acute care admission into Hospice:

i. The member's home;
ii. A distinct part of a hospital psychiatric or rehabilitation unit;
iii. A home-based community setting; or
iv. A transition into the home.

I. Admission to Out of Network (OON) or Out of Area Facilities

1. Emergency admission to an ~~Out of Network~~OON or Out of Area ~~f~~Facility will be followed by the UM or Behavioral Health (BH) Department. The UM/BH Clinical Reviewer will follow the member, utilizing the above guidelines, until the member is able to be safely transferred back into the appropriate network. The LOA process will be enacted for the Out of Network facility as needed or invited to contract with AAH.
2. The UM/BH Department will collaborate on a plan of care for a member who is being prior-authorized for out-of-area/network care. This includes referral to the TCS program to ensure that the safe and appropriate discharge plan and follow up care is enacted. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
3. The Member Services department will be notified if it appears that the member has moved permanently out of the area.

J. Coordination with Behavioral Health

1. Admissions related to behavioral health conditions are managed by the behavioral health staff and in compliance with the regulatory requirements and most recent DHCS All Plan Letter related to Medi-Cal Managed Care Health Plan Responsibilities for Mental Health Services.
2. Behavioral health admissions are co-managed when necessary to ensure the collaboration of medical and behavioral health services. AAH will facilitate access to necessary medical information and services for transition or discharge planning.
3. Members identified with need for medical case management services will be referred as defined in CM policy.

L. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS AND ACRONYMS

Concurrent request – A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

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Discharge Planning – The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and potentially other health professionals; its goal is to enhance continuity of care. It begins on admission.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

BH-001 Behavioral Health Services
CM-001 Complex Case Management Identification, Screening Assessment and Triage
CMP-019 Delegation Oversight
UM-001 Utilization Management Program UM-051 Timeliness of UM Decision Making
UM-052 Discharge Planning to Lower Level of Care, Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days
UM-054 Notice of Action
UM-057 Authorization Request UM-060 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/21/2006, 1/1/2008, 1/16/2009, 4/13/2011, 9/7/2012, 7/13/2013, 3/14/2014, 12/9/2016, 12/15/2016, 4/12/2018, 04/15/2019, 09/19/2019, 1/21/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023, 7/17/2024, 8/26/2024

REFERENCES

1. 45 CFR §146.136 Mental Health Parity and Addiction Equity Act
2. DHCS Contract, Exhibit A, Attachment 5, Provisions 2 and 3
3. DHCS PHM Policy Guide May 2024
4. DHCS PHM FAQ June 2024
5. Title 42, CFR, Sections 422.118 and 422.620

MONITORING

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6/28/2022

POLICY AND PROCEDURE

Policy Number	UM-011
Policy Name	Coordination of Care - Hospice Services and Terminal Illness
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Hospice

A. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services.

B. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.

C. Hospice Care is not Long-Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.

D. The "election period" for hospice services consists of the following: (1) an initial 90 day period; (2) a subsequent 90 day period; or (3) an unlimited number of 60 day periods.

E. These services include, but are not limited to:

1. Nursing services.
2. Physical, occupational, or speech language pathology.
3. Medical social services under the direction of a physician.
4. Home health aide and homemaker services.
5. Medical supplies and appliances.
6. Drugs and biological.
7. Physician services

8. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.
9. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis as necessary to maintain the terminally ill member at home.
10. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
11. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
12. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

F. Prior Authorization may not be required for routine home care, continuous home care, respite care, or hospice physician services. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient care.

G. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.

H. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).

I. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit. See APL 13-014 for reimbursement guidelines.

J. Services not covered by a hospice provider include:
   1. Private pay room and board or residential care
   2. Acute in-patient hospitalization unrelated to the terminal illness
   3. Level A or B nursing facility (NF) for unrelated issues
   4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
   5. Other necessary services for conditions unrelated to the terminal illness.

K. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See MMCD Policy Letter PL 11- 004.

Terminal Illness

The Alliance will comply with CA Health and Safety Code regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.

PROCEDURE

Hospice

A. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

B. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:

1. Identification of the hospice;
2. The Member's or representative's acknowledgement that:
    a. There is a full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.
    b. Certain specified Medi-Cal benefits are waived by the election.
3. The effective date of the election;
4. The signature of the Member or representative.

C. A Member's voluntary election may be revoked or modified at any time.

1. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;
2. A Member or representative may:
    a. Execute a new election for any remaining entitled election period at any time after revocation;
    b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

D. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.

E. If the member is residing in a Long-Term Care Facility

1. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a nursing facility (NF) or Intermediate Care Facility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.
2. The hospice will then reimburse the NF for the room and board at the rate negotiated between the hospice and the NF
3. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.
    a. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.

Terminal Illness

A. The Alliance shall provide the following information to an enrollee with a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider:

1. A statement setting forth the specific medical and scientific reasons for

denying coverage.

2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

B. Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:
   1. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);
   2. Conducted by a plan representative having authority to determine the disposition of the complaint;
   3. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;
   4. However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

C. Guidelines to Identify a Terminally Ill Diagnosis or Condition
   1. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity Committee (QIHEC)
   2. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.
   3. Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:
      1) Levels of Care
         (a) Routine home care
         (b) Continuous home care requiring a minimum of eight hours of care per 24-hour period
         (c) Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time
         (d) General Inpatient care for pain and symptom control
            i. Documents to be submitted for authorization include:
               1. Certification of physician orders for general inpatient care.
               2. Justification for this level of care.

4. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

D. Communication of Denial Determination

1. Requesting provider and Member written notifications for denied requests related to a terminal illness will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.
2. The denial Notice of Action (NOA) letter includes statements about the specific medical and scientific reasons for denying coverage.
3. The denial NOA letter will include, if appropriate, a description of alternative treatment, service, or supply covered by the Alliance.

DEFINITIONS / ACRONYMS

A. Terminally ill is defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

B. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

C. Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarily on reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)

D. Crisis is the period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is needed.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 10/30/2013, 3/04/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 10/25/2024

REFERENCES

A. CA Health and Safety Code §1368.1(a) (b)
B. DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.
C. CCS NL: 04-0207 Palliative Options for CCS Eligible Children
D. CCS NL: 06-1011 Authorization-Concurrent Treatment for CCS Clients Who Elect Hospice
E. MMCD All Plan Letter 13-014 Hospice Services and MCMC
F. MMCD Policy Letter 11-004 ACA –Concurrent Care for Children
G. Title 22, CCR, Sections 51180 and 51349
H. Social Security Act §1905(o)(1)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

6/28/2022

POLICY AND PROCEDURE

Policy Number	UM-011
Policy Name	Coordination of Care - Hospice Services and Terminal Illness
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~10/11/2023~~TBD
Compliance Committee Approval Date	~~10/19/2023~~TBD

POLICY STATEMENT

Hospice

A. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services.

B. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.

C. Hospice Care is not Long–Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.

D. The "election period" for hospice services consists of the following: (1) an initial 90 day period; (2) a subsequent 90 day period; or (3) an unlimited number of 60 day periods.

E. These services include, but are not limited to:

1. Nursing services.
2. Physical, occupational, or speech language pathology.
3. Medical social services under the direction of a physician.
4. Home health aide and homemaker services.
5. Medical supplies and appliances.
6. Drugs and biological.
7. Physician services

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~~7.~~8. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.

~~8.~~9. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis as necessary to maintain the terminally ill member at home.

~~9.~~10. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.

~~10.~~11. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.

~~11.~~12. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

F. Prior Authorization may not be required for routine home care, continuous home care, respite care, or hospice physician services. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient ~~and continuous~~ care.

G. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.

H. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).

I. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit. See APL 13-014 for reimbursement guidelines.

J. Services not covered by a hospice provider include:

1. Private pay room and board or residential care
2. Acute in-patient hospitalization unrelated to the terminal illness
3. Level A or B nursing facility (NF) for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
5. Other necessary services for conditions unrelated to the terminal illness.

K. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See MMCD Policy Letter PL 11- 004.

Terminal Illness

The Alliance will comply with CA Health and Safety Code regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.

PROCEDURE

Hospice

A. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

B. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:

1. Identification of the hospice;
2. The Member's or representative's acknowledgement that:
   a. There is a ~~He or she has~~ full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.
   b. Certain specified Medi-Cal benefits are waived by the election.
3. The effective date of the election;
4. The signature of the Member or representative.

C. A Member's voluntary election may be revoked or modified at any time.

1. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;
2. A Member or representative may:
   a. Execute a new election for any remaining entitled election period at any time after revocation;
   b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

D. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.

E. If the member is residing in a Long-Term Care Facility

1. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a ~~n~~nursing facility (NF) or ~~I~~intermediate Ceare F~~f~~acility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.
2. The hospice will then reimburse the NF~~G~~ for the room and board at the rate negotiated between the hospice and the NF
3. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.
   a. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.

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Terminal Illness

A. The Alliance shall provide the following information to an enrollee with a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

B. UUpon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:

1. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);
2. Conducted by a plan representative having authority to determine the disposition of the complaint;
3. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;
4. However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

C. Guidelines to Identify a Terminally Ill Diagnosis or Condition

1. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity Committee (QIHEC) ~~Health Care Quality Committee (HCQC).~~
2. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.
3. Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:
   1) Levels of Care
      (a) Routine home care
      (b) Continuous home care requiring a minimum of eight hours of care per 24-hour period
      (c) Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time
      (d) General Inpatient care for pain and symptom control
         i. Documents to be submitted for authorization include:
            1. Certification of physician orders for general inpatient care.
            2. Justification for this level of care.
4. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

D. ~~CI.~~ Communication of Denial Determination

1. Requesting provider and Member written notifications for denied requests related to a terminal illness will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.
2. The denial Notice of Action (NOA) letter includes statements about the specific medical and scientific reasons for denying coverage.

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3. The denial NOA letter will include, if appropriate, a description of alternative treatment, service, or supply covered by the Alliance.

DEFINITIONS / ACRONYMS

A. Terminally ill is defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.

2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

B. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

C. Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarily on reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)

D. Crisis is the period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is needed.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 10/30/2013, 3/04/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 10/25/2024

REFERENCES

A. CA Health and Safety Code §1368.1(a) (b)
B. DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.
~~E. MMCD All Plan Letter 13-014 Hospice Services and MCMC~~
~~F. MMCD Policy Letter 11-004 ACA –Concurrent Care for Children~~
~~G.~~C. CCS NL: 04-0207 Palliative Options for CCS Eligible Children
D. CCS NL: 06-1011 Authorization-Concurrent Treatment for CCS Clients Who Elect Hospice
E. MMCD All Plan Letter 13-014 Hospice Services and MCMC
~~H.~~MMCD Policy Letter 11-004 ACA –Concurrent Care for Children
~~I.~~F. ~~DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.~~

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~~J.~~G. Title 22, CCR, Sections 51180 and 51349
~~K.~~H. Social Security Act §1905(o)(1)
~~L. CA Health and Safety Code §1368.1(a) (b)~~

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee~~Healthcare Quality Committee~~ annually.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

All trips of more than 50 miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form, not to exceed 12 months.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with the MCP contract. AAH authorizes, at a

minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests and has a direct line to AAH's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides. The transportation liaison ensures that authorizations are being processed during and after business hours. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a

psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

Use of Physician Certification Statement Forms

The member's provider must submit the PCS Form to the AAH for the approval of NEMT services and AAH uses the PCS form to provide the appropriate mode of NEMT for members. Once the member's treating provider prescribes the mode of NEMT, AAH does not modify the PCS Form. AAH has a process in place to share the PCS Form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. AAH reviews and approves of the PCS. AAH will ensure that contracts with the transportation broker will comply with the requirements set forth in APL 23-006, APL 22-013, APL 21-011, APL 22-008, and the MCP Contract.

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including

pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
  - Medically necessary covered services.
  - Members picking up drug prescriptions that cannot be mailed directly to the member.
  - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license;
  - Has no working vehicle available in the household;
  - Is unable to travel or wait for medical or dental services alone; or
  - Has a physical, cognitive, mental, or developmental limitation.

Commented [MJA1]: Added the APL language back about coverage for member and one attendants, but took out auth word--we would pay for a bus ticket for an attendant.

Non-Medical Transportation Private Vehicle Authorization Requirements

AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the

member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization
AAH does not require prior authorization for NMT services.

Minor Requirements
Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers
AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide

reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form; and
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services.
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;
- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

   i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

   ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

   AAH uses the Department of Health Care Services (DHCS) approved PCS form.

   iii) At a minimum, the following components are included in the PCS form:

   (a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

   (b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

   (c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

   (i) Ambulance services will be provided for:

   1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.

   2. Transfers from an acute care facility to another acute care facility.

3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. Emergency Medical Transportation: is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary

and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

   (a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

ii) For transportation trips that exceed the 50-mile limit, the requesting provider/ hospital will submit the AAH Prior Authorization Form to the AAH UM team via Portal or Fax.

   (a) The UM team will process the request within the required time frame and fax a copy of the authorization to the Transportation Vendor once a decision is rendered.

5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and

mitigation of potential harm to the member.

c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.
d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.
e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. **RideShare Pilot**

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS / ACRONYMS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)
Transportation Template

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023, 7/17/2024, 8/28/2024

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)
DHCS APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates
DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services
DHCS APL 22-013 Provider Credentialing/ Re-Credentialing and Screening/ Enrollment
DHCS APL 23-006 Delegation and Subcontractor Network Certification
DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

This policy will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	~~7/17/2024~~TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

All trips of more than 50 ~~or more~~ miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form, not to exceed 12 months.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with the MCP contract. AAH authorizes, at a

minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests and has a direct line to AAH's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides. The transportation liaison ensures that authorizations are being processed during and after business hours. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a

psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

Use of Physician Certification Statement Forms

The member's provider must submit the PCS Form to the AAH for the approval of NEMT services and AAH uses the PCS form to provide the appropriate mode of NEMT for members. Once the member's treating provider prescribes the mode of NEMT, AAH does not modify the PCS Form. AAH has a process in place to share the PCS Form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. AAH reviews and approves of the PCS. AAH will ensure that contracts with the transportation broker will comply with the requirements set forth in APL ~~17-004~~23-006, APL ~~19-004~~22-013, APL 21-011, APL 22-008, and the MCP Contract.

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including

pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
  - Medically necessary covered services.
  - Members picking up drug prescriptions that cannot be mailed directly to the member.
  - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license;
  - Has no working vehicle available in the household;
  - Is unable to travel or wait for medical or dental services alone; or
  - Has a physical, cognitive, mental, or developmental limitation.

Commented [MJA1]: Added the APL language back about coverage for member and one attendants, but took out auth word--we would pay for a bus ticket for an attendant.

Non-Medical Transportation Private Vehicle Authorization Requirements

AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the

member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization
AAH does not require prior authorization for NMT services.

Minor Requirements
Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers
AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide

reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form; and
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services.
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;
- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

   i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

   ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

   AAH uses the Department of Health Care Services (DHCS) approved PCS form.

   iii) At a minimum, the following components are included in the PCS form:

   (a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

   (b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

   (c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

   (i) Ambulance services will be provided for:

   1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.

   2. Transfers from an acute care facility to another acute care facility.

3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. <u>Emergency Medical Transportation</u>: is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

(a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

ii) For transportation trips that exceed the 50-mile limit, the requesting provider/ hospital will submit the AAH Prior Authorization Form to the AAH UM team via Portal or Fax.

(a) The UM team will process the request within the required time frame and fax a copy of the authorization to the Transportation Vendor once a decision is rendered.

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5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the

transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.

c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.
d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.
e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. **RideShare Pilot**

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS / ACRONYMS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management
Utilization Management

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RELATED POLICIES AND PROCEDURES

UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)
Transportation Template

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023, 7/17/2024, 8/28/2024

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)
DHCS APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates
DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services
~~APL 17-00423-006 DELEGATION AND SUBCONTRACTOR NETWORK CERTIFICATIONSubcontractual Relationships and Delegation~~
DHCS APL ~~19-00~~422-013 Provider Credentialing/ Re-Credentialing and Screening/ Enrollment ~~ROVIDER CREDENTIALING / RE-CREDENTIALING AND SCREENING / ENROLLMENTProvider Credentialing/Recredentialing and Screening/Enrollment~~
DHCS APL 23-006 Delegation and Subcontractor Network Certification ~~APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates~~

DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

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MONITORING

This policy will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

All trips of more than 50 miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form, not to exceed 12 months. Once the member's treating provider prescribes the mode of NEMT, neither AAH nor its subcontractor modify the PCS Form.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal

and administrative management, in accordance with the MCP contract. AAH authorizes, at a minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

AAH's transportation coordinators facilitate the acquisition and completion of PCS form by the member's treating providers before the trip occurs. AAH reviews and approved the PCS form. AAH has a process in place to share PCS data with the transportation subcontractor.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Transportation Liaison

AAH has a direct line to its transportation liaison for providers and members to call to ensure eligible urgent and non-urgent transportation requests are authorized and scheduled. The direct line to the transportation liaison is listed in the member handbook and provider handbook.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or

otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license;
    - Has no working vehicle available in the household;
    - Is unable to travel or wait for medical or dental services alone; or
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a

private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization

AAH does not require prior authorization for NMT services.

Minor Requirements

Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers

AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and

NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals

as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Spot Checking of Trips
To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker.

Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form;
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services. The NEMT provider is providing ambulatory door-to-door assistance for members receiving NEMT services;
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;

- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

   i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

   ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

   AAH uses the Department of Health Care Services (DHCS) approved PCS form.

   iii) At a minimum, the following components are included in the PCS form:

   (a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

   (b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

   (c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

   (i) Ambulance services will be provided for:

1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
2. Transfers from an acute care facility to another acute care facility.
3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. **Emergency Medical Transportation**: is provided when a member's medical condition

is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

   (a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

ii) For transportation trips that exceed the 50-mile limit, the requesting provider/ hospital will submit the AAH Prior Authorization Form to the AAH UM team via Portal or Fax.

   (a) The UM team will process the request within the required time frame and fax a copy of the authorization to the Transportation Vendor once a decision is rendered.

5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.
c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.
d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.
e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. RideShare Pilot

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS / ACRONYMS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management
Utilization Management

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)

Transportation Template

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023, 7/17/2024, 8/28/2024

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)

DHCS APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates

DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services

DHCS APL 22-013 Provider Credentialing/ Re-Credentialing and Screening/ Enrollment

DHCS APL 23-006 Delegation and Subcontractor Network Certification

DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

This policy will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

All trips of more than 50 miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form, not to exceed 12 months. Once the member's treating provider prescribes the mode of NEMT, neither AAH nor its subcontractor modify the PCS Form.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal

and administrative management, in accordance with the MCP contract. AAH authorizes, at a minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

AAH's transportation coordinators facilitate the acquisition and completion of PCS form by the member's treating providers before the trip occurs. AAH reviews and approved the PCS form. AAH has a process in place to share PCS data with the transportation subcontractor.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Transportation Liaison

AAH has a direct line to its transportation liaison for providers and members to call to ensure eligible urgent and non-urgent transportation requests are authorized and scheduled. The direct line to the transportation liaison is listed in the member handbook and provider handbook.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests. ~~and has a direct line to AAH's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides. The transportation liaison ensures that authorizations are being processed during and after business hours.~~ AAH informs members

that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

~~**Use of Physician Certification Statement Forms**~~

~~The member's provider must submit the PCS Form to the AAH for the approval of NEMT services and AAH uses the PCS form to provide the appropriate mode of NEMT for members. Once the member's treating provider prescribes the mode of NEMT, AAH does not modify the PCS Form. AAH has a process in place to share the PCS Form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. AAH~~

~~reviews and approves of the PCS. AAH will ensure that contracts with the transportation broker will comply with the requirements set forth in APL 23-006, APL 22-013, APL 21-011, APL 22-008, and the MCP Contract.~~

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license;
    - Has no working vehicle available in the household;
    - Is unable to travel or wait for medical or dental services alone; or
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements
AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization
AAH does not require prior authorization for NMT services.

Minor Requirements
Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers
AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes

place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Spot Checking of Trips
To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker.

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Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all

applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers ~~.~~;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form; ~~and~~
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services. The NEMT provider is providing ambulatory door-to-door assistance for members receiving NEMT services;
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;
- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.~~; and~~.
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PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

    i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

    ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

AAH uses the Department of Health Care Services (DHCS) approved PCS form.

iii) At a minimum, the following components are included in the PCS form:

(a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

(b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

(c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

(i) Ambulance services will be provided for:

1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
2. Transfers from an acute care facility to another acute care facility.
3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated

in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. Emergency Medical Transportation: is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

(a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

ii) For transportation trips that exceed the 50-mile limit, the requesting provider/ hospital will submit the AAH Prior Authorization Form to the AAH UM team via

Portal or Fax.

(a) The UM team will process the request within the required time frame and fax a copy of the authorization to the Transportation Vendor once a decision is rendered.

5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.
c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.
d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.
e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. RideShare Pilot

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS / ACRONYMS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)

Transportation Template

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023, 7/17/2024, 8/28/2024

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)

DHCS APL 21-011 Grievance and Appeals Requirements, Notice and “Your Rights’ Templates

DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services

DHCS APL 22-013 Provider Credentialing/ Re-Credentialing and Screening/ Enrollment

DHCS APL 23-006 Delegation and Subcontractor Network Certification

DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

This policy will be reviewed annually to ensure effectiveness and compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) for individuals 21 years of age or older: services are determined to be medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain are covered by AAH. For individuals under 21 years of age, services must meet the standards set forth in Section 1396(5) of Title 42 of the US Code., which includes: screening services, vision, dental and hearing services.

B. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the AAH contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

C. A service does not need to cure a condition in order to be covered under EPSDT (Medi-Cal for Kids & Teens.) Services that maintain or improve the child's current health condition are also covered under EPSDT (Medi-Cal for Kids & Teens,) because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health

problems. The common definition of "ameliorate" is to "make more tolerable or to make better." Additional services are provided if determined to be medically necessary for an individual child.

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

E. Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT (Medi-Cal for Kids & Teens,) covered service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. AAH applies this definition when determining if a service is medically necessary or a medical necessity for any Member under the age of 21.

F. Coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines as outlined by Bright Futures/the American Academy of Pediatrics (AAP) AAH uses the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to screening services, vision services, and hearing services. AAH provides all age-specific assessments and services required by the DHCS Contract and the AAP/Bright Futures periodicity schedule. AAH provides any medically necessary EPSDT (Medi-Cal for Kids & Teens,) services that exceed those recommended by AAP/Bright Futures.

G. AAH provides Members with appropriate referrals for diagnosis and treatment without delay. AAH is also responsible for ensuring Members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Services are initiated within timely access standards whether or not the services are Covered Services.

H. AAH provides case management and care coordination for all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services.

I. AAH exchanges necessary data for the provision of services as well as the coordination of non-covered services such as social support services.

J. The Alliance determines if a Medi-Cal Member requires EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) services through a participating local government agency or through an organization such as the Regional Center of the East Bay (RCEB).

K. AAH ensures the coverage of Targeted Case Management (TCM) services. The Alliance is responsible for assisting in the coordination of care for members who require Targeted Case Management (TCM) services to a Regional Center or local governmental health program. The Alliance is responsible for coordinating the member's health care with the

TCM provider.

L. The Alliance will determine the medical necessity of diagnostic and treatment services recommended by the TCM provider and covered under the contract and will authorize approved services. If AAH determines that a Member is not eligible for TCM services, AAH will ensure that the Member's access to services is comparable to EPSDT (Medi-Cal for Kids & Teens,) TCM services.

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

N. The plan will provide and pay for EPSDT (Medi-Cal for Kids and Teens,) supplemental services, except for those services provided under California Children Services (CCS) and those targeted case management services (TCM) receiving funding through other mechanisms (dental, specialty mental health services and Substance Use Disorder Services)

O. The Alliance will provide access to medically necessary diagnostic and treatment services, including but not limited to BHT (Behavioral Health Treatment) services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. AAH provides medically necessary Behavioral Health Treatment (BHT) services consistent with the requirements in APL 23-005, for eligible Members under the age of 21.

P. The Alliance will provide appointment scheduling assistance if needed and necessary non-emergency medical transportation (NMT) for services.

Q. The Alliance must inform members or their families about EPSDT, (Medi-Cal for Kids and Teens,) how to obtain services, transportation, health education, anticipatory guidance (members under 21) in the members' primary language.

PROCEDURE EPSDT (Medi-Cal for Kids and Teens) Services

A. Member needs for EPSDT (Medi-Cal for Kids and Teens,) Services are determined primarily through initial and periodic health assessments by the Member's PCP in accordance with Child Health and Disability Prevention Program (CHDP) required services. The need for EPSDT (Medi-Cal for Kids and Teens,) supplemental services may also be identified by the Member, the Member's parent or other family members, through a Member's encounter with a health care practitioner, or from the Utilization Management staff while reviewing prior authorization requests.

B. If a PCP, specialist Alliance case manager identifies the need for a health care service for a Member under age 21 that is not covered by the Alliance, the service may be available as an EPSDT (Medi-Cal for Kids and Teens,) service. The PCP or specialist must request the

services from the Alliance and document the rationale for the request in the medical record. Alliance Utilization Management (UM) will assess if the service is medically necessary, regardless of whether or not it is a defined benefit.

C. Examples of EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services are: cochlear implants, EPSDT (Medi-Cal for Kids and Teens,) CM services and EPSDT (Medi-Cal for Kids and Teens,) supplemental nursing services. EPSDT (Medi-Cal for Kids and Teens,) services also include additional services beyond those otherwise limited to two-per-month with Medi- Cal. These services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

EPSDT (Medi-Cal for Kids and Teens,) Nursing Services

A. EPSDT (Medi-Cal for Kids and Teens,) nursing services include hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home.

EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) Services

A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
    4. Developing a specific care plan for the Member as needed.

B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization including but not limited to the following:
    1. RCEB
    2. Children's Hospital
    3. City of Fremont – Linkages
    4. City of Fremont - FFRC
    5. City of Oakland
    6. Covenant House California
    7. Public Health Department

8. Roots Community Health Center
9. Probation Department
10. Tiburcio Vasquez Health Center

If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will share minimum necessary information with the entity to ensure the specific needs of the member at met, through secure resources (for example, but not limited to, secure email or sFTP shared site).

D. Specialized EPSDT (Medi-Cal for Kids and Teens) CM services may be provided by a Targeted Case Management (TCM) entity (e.g., RCEB), a child protection agency, other agencies or entities serving children, or an individual practitioner whom the Alliance finds qualified by education, training, or experience to provide specialized CM services. Alliance CM is responsible for arranging the necessary case management for Members.

E. If a Member receives TCM or specialized EPSDT (Medi-Cal for Kids and Teens) CM services, Alliance CM is required to coordinate those services with the PCP and/or specialist practitioner. This includes coordination with RCEB CM as well as any other agencies' CM staff providing the services.

F. EPSDT (Medi-Cal for Kids and Teens) CM services may be provided by the Alliance, RCEB, Child Protective Services, or the Department of Mental Health as needed.

Targeted Case Management Services

A. The Alliance and PCPs are responsible for determining whether members require Targeted Case Management (TCM) services, and for referring members who are eligible for TCM services to RCEB or the local government health program as appropriate for the provision of TCM services.

1. The Alliance maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) and Alameda County for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of targeted case management for Medi-Cal members enrolled in the Alliance.

B. TCM services provided by RCEB include at least one of the following, as described in Title 22, CCR, Section 51351:

1. A documented assessment identifying the member's needs;
2. The development of a comprehensive, written, individual service plan, based upon the assessment;
3. The implementation of the service plan, which includes linkage and consultation with and referral to providers of service;
4. Assistance with accessing the services identified in the service plan;
5. Crisis assistance planning to coordinate and arrange immediate services or treatment needed in those situations that appear to be emergent in nature; and
6. Periodic review of the member's progress toward achieving the service outcomes identified in the service plan;

C. If a member is receiving TCM services as specified in Title 22, CCR, Section 51351, the Alliance is responsible for coordinating the member's health care with the TCM provider and for providing Care Coordination for all Medically Necessary Covered Services

identified by the TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services.

1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.
    a. This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication with the other entity regarding the delegation of services needed by the member.

D. The Alliance designates an RCEB liaison responsible for coordinating TCM services with RCEB and local government agencies, if needed.
    1. Responsibilities of the liaison include, but not limited to: sharing appropriate member provider(s) information, PCP information, care manager assignment with RCEB and local government agencies as needed, and resolving all related operational issues
        a. The Alliance notifies member's PCP and/or care managers when members are receiving TCM services and provides them with appropriate local governmental agency contact information.

E. For members under the age of twenty-one (21), not accepted by RCEB for TCM services, the Alliance ensures that they have access to comparable EPSDT (Medi-Cal for Kids and Teens,) TCM services.

Behavioral Health Services

A. The provision of EPSDT (Medi-Cal for Kids and Teens,) services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of the Alliance:
    1. Effective on the date of the member's transition from the RC
    2. For new members, upon MCP enrollment

B. Criteria for BHT Services:
    1. Be under 21 years of age.
    2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
    3. Be medically stable.
    4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Alliance is responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services

C. BHT Covered Services:

1. Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2. Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3. Provided by California State Plan approved providers as defined in SPA 14-026.9 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

D. BHT services are provided under a behavioral treatment plan:

1. The BHT treatment plan must have measurable goals over a specific timeline for the specific member
2. The BHT treatment plan must be developed by a BHT Service Provider.
3. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider.
4. The behavioral treatment plan may be modified if medically necessary.
5. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
   1. Services rendered when continued clinical benefit is not expected.
   2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
   3. Treatment whose sole purpose is vocationally- or recreationally-based.
   4. Custodial care. For purposes of BHT services, custodial care:
      a. Is provided primarily for maintaining the member's or anyone else's safety.
      b. Could be provided by persons without professional skills or training.
   5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
   6. Services rendered by a parent, legal guardian, or legally responsible person.
   7. Services that are not evidence-based behavioral intervention practices.

F. The approved behavioral treatment plan must meet the following criteria:

1. Be developed by a BHT Service Provider for the specific member being treated.
2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.

6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
13. Include an exit plan/ criteria.

G. Continuity of care:

1. The Alliance must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services.
2. At least 45 days prior to the transition date, DHCS will provide the Alliance with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members.
3. The Alliance will utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary.
4. The Alliance must make a good faith effort to proactively contact the provider to begin the continuity of care process.
5. The Alliance must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:
    a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the

transition of services from the RC to the Alliance or the date of the member's initial enrollment in the Alliance if enrollment occurred on or after July 1, 2018.

b. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.

c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance's network.

d. The provider is a California State Plan approved provider.

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

6. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance must assign the member to that provider to continue BHT services.

7. BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Alliance provider.

8. If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the Alliance, the Alliance must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the Alliance approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, the Alliance must conduct an Outbound Call Campaign, as described below.

A. Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
B. Make five call attempts to reach the member (or his/her parent/guardian).
C. Inform the member of the transition and the continuity of care process.
D. Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

The Alliance will report metrics to DHCS related to the requirements in a manner determined by DHCS.

DELEGATION OVERSIGHT: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-

019 for monitoring of delegation oversight.

DEFINITIONS

EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services: Services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or other condition that must be provided to an Alliance member under 21 years of age.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-019 Delegation Oversight

REVISION HISTORY

1/1/2008, 10/28/2009, 4/1/2011, 8/30/2012, 01/10/2016, 12/15/2016, 7/19/2018, 8/3/2018, 09/06/2018, 11/21/2019, 7/31/20, 9/17/2020, 03/22/2022, 12/19/2023, 10/25/24

REFERENCES

APL 18-008 Continuity of Care
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Title 42, Section 1396d(R)(5)
Welfare and Institutions Code, CCR, Section 14132.44

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) annually.

POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

POLICY STATEMENT

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) for individuals 21 years of age or older: services are determined to be medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain are covered by AAH. For individuals under 21 years of age, services must meet the standards set forth in Section 1396(5) of Title 42 of the US Code., which includes: screening services, vision, dental and hearing services.

B. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the AAH contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

~~B.~~

C. A service does not need to cure a condition in order to be covered under EPSDT (Medi-Cal for Kids & Teens.) Services that maintain or improve the child's current health condition are also covered under EPSDT (Medi-Cal for Kids & Teens,) because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health

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problems. The common definition of "ameliorate" is to "make more tolerable or to make better." Additional services are provided if determined to be medically necessary for an individual child.

~~C.~~

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

~~D.~~

E. Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT (Medi-Cal for Kids & Teens,) covered service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. AAH applies this definition when determining if a service is medically necessary or a medical necessity for any Member under the age of 21.

~~E.~~

F. Coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines as outlined by Bright Futures/the American Academy of Pediatrics (AAP) AAH uses the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to screening services, vision services, and hearing services. AAH provides all age-specific assessments and services required by the DHCS Contract and the AAP/Bright Futures periodicity schedule. AAH provides any medically necessary EPSDT (Medi-Cal for Kids & Teens,) services that exceed those recommended by AAP/Bright Futures.

G. AAH provides Members with appropriate referrals for diagnosis and treatment without delay. AAH is also responsible for ensuring Members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Services are initiated within timely access standards whether or not the services are Covered Services.

~~G.~~

H. AAH provides case management and care coordination for all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services.

I. AAH exchanges necessary data for the provision of services as well as the coordination of non-covered services such as social support services.

~~I.~~

J. The Alliance determines if a Medi-Cal Member requires EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) services through a participating local government agency or through an organization such as the Regional Center of the East Bay (RCEB).

~~J.~~

K. AAH ensures the coverage of Targeted Case Management (TCM) services. The Alliance is responsible for assisting in the coordination of care for members who require Targeted Case Management (TCM) services to a Regional Center or local governmental health program. The Alliance is responsible for coordinating the member's health care with the

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TCM provider.

~~K.~~

L. The Alliance will determine the medical necessity of diagnostic and treatment services recommended by the TCM provider and covered under the contract and will authorize approved services. If AAH determines that a Member is not eligible for TCM services, AAH will ensure that the Member's access to services is comparable to EPSDT (Medi-Cal for Kids & Teens,) TCM services.

~~L.~~

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

~~M.~~

N. The plan will provide and pay for EPSDT (Medi-Cal for Kids and Teens,) supplemental services, except for those services provided under California Children Services (CCS) and those targeted case management services (TCM) receiving funding through other mechanisms (dental, specialty mental health services and Substance Use Disorder Services)

O. The Alliance will provide access to medically necessary diagnostic and treatment services, including but not limited to BHT (Behavioral Health Treatment) services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. AAH provides medically necessary Behavioral Health Treatment (BHT) services consistent with the requirements in APL 23-005, for eligible Members under the age of 21.

P. The Alliance will provide appointment scheduling assistance if needed and necessary non-emergency medical transportation (NMT) for services.

Q. The Alliance must inform members or their families about EPSDT, (Medi-Cal for Kids and Teens,) how to obtain services, transportation, health education, anticipatory guidance (members under 21) in the members' primary language.

PROCEDURE EPSDT (Medi-Cal for Kids and Teens~~,~~) Services

A. Member needs for EPSDT (Medi-Cal for Kids and Teens,) Services are determined primarily through initial and periodic health assessments by the Member's PCP in accordance with Child Health and Disability Prevention Program (CHDP) required services. The need for EPSDT (Medi-Cal for Kids and Teens,) supplemental services may also be identified by the Member, the Member's parent or other family members, through a Member's encounter with a health care practitioner, or from the Utilization Management staff while reviewing prior authorization requests.

B. If a PCP, specialist Alliance case manager identifies the need for a health care service for a Member under age 21 that is not covered by the Alliance, the service may be available as

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an EPSDT (Medi-Cal for Kids and Teens,) service. The PCP or specialist must request the services from the Alliance and document the rationale for the request in the medical record. Alliance Utilization Management (UM) will assess if the service is medically necessary, regardless of whether or not it is a defined benefit.

C. Examples of EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services are: cochlear implants, EPSDT (Medi-Cal for Kids and Teens,) CM services and EPSDT (Medi-Cal for Kids and Teens,) supplemental nursing services. EPSDT (Medi-Cal for Kids and Teens,) services also include additional services beyond those otherwise limited to two-per-month with Medi- Cal. These services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

EPSDT (Medi-Cal for Kids and Teens,) Nursing Services

A. EPSDT (Medi-Cal for Kids and Teens,) nursing services include hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home.

EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) Services

A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
    4. Developing a specific care plan for the Member as needed.

B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization including but not limited to the following:
    1. RCEB
    2. Children's Hospital
    3. City of Fremont – Linkages
    4. City of Fremont - FFRC
    5. City of Oakland
    6. Covenant House California

7. Public Health Department
8. Roots Community Health Center
9. Probation Department
10. Tiburcio Vasquez Health Center

If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will share minimum necessary information with the entity to ensure the specific needs of the member at met, through secure resources (for example, but not limited to, secure email or sFTP shared site).

D. Specialized EPSDT (Medi-Cal for Kids and Teens~~,~~) CM services may be provided by a Targeted Case Management (TCM) entity (e.g., RCEB), a child protection agency, other agencies or entities serving children, or an individual practitioner whom the Alliance finds qualified by education, training, or experience to provide specialized CM services. Alliance CM is responsible for arranging the necessary case management for Members.

E. If a Member receives TCM or specialized EPSDT (Medi-Cal for Kids and Teens~~,~~) CM services, Alliance CM is required to coordinate those services with the PCP and/or specialist practitioner. This includes coordination with RCEB CM as well as any other agencies' CM staff providing the services.

F. EPSDT (Medi-Cal for Kids and Teens~~,~~) CM services may be provided by the Alliance, RCEB, Child Protective Services, or the Department of Mental Health as needed.

Targeted Case Management Services

A. The Alliance and PCPs are responsible for determining whether members require Targeted Case Management (TCM) services, and for referring members who are eligible for TCM services to RCEB or the local government health program as appropriate for the provision of TCM services.

1. The Alliance maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) and Alameda County for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of targeted case management for Medi-Cal members enrolled in the Alliance.

B. TCM services provided by RCEB include at least one of the following, as described in Title 22, CCR, Section 51351:

1. A documented assessment identifying the member's needs;
2. The development of a comprehensive, written, individual service plan, based upon the assessment;
3. The implementation of the service plan, which includes linkage and consultation with and referral to providers of service;
4. Assistance with accessing the services identified in the service plan;
5. Crisis assistance planning to coordinate and arrange immediate services or treatment needed in those situations that appear to be emergent in nature; and
6. Periodic review of the member's progress toward achieving the service outcomes identified in the service plan;

C. If a member is receiving TCM services as specified in Title 22, CCR, Section 51351, the

Alliance is responsible for coordinating the member's health care with the TCM provider and for providing Care Coordination for all Medically Necessary Covered Services identified by the TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services.

1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.
    a. This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication with the other entity regarding the delegation of services needed by the member.

D. The Alliance designates an RCEB liaison responsible for coordinating TCM services with RCEB and local government agencies, if needed.
    1. Responsibilities of the liaison include, but not limited to: sharing appropriate member provider(s) information, PCP information, care manager assignment with RCEB and local government agencies as needed, and resolving all related operational issues
        a. The Alliance notifies member's PCP and/or care managers when members are receiving TCM services and provides them with appropriate local governmental agency contact information.

E. For members under the age of twenty-one (21), not accepted by RCEB for TCM services, the Alliance ensures that they have access to comparable EPSDT (Medi-Cal for Kids and Teens,) TCM services.

Behavioral Health Services

A. The provision of EPSDT (Medi-Cal for Kids and Teens,) services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of the Alliance:
    1. Effective on the date of the member's transition from the RC
    2. For new members, upon MCP enrollment

B. Criteria for BHT Services:
    1. Be under 21 years of age.
    2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
    3. Be medically stable.
    4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Alliance is responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services

C. BHT Covered Services:
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1. Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2. Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3. Provided by California State Plan approved providers as defined in SPA 14-026.9 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

D. BHT services are provided under a behavioral treatment plan:

1. The BHT treatment plan must have measurable goals over a specific timeline for the specific member
2. The BHT treatment plan must be developed by a BHT Service Provider.
3. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider.
4. The behavioral treatment plan may be modified if medically necessary.
5. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
1. Services rendered when continued clinical benefit is not expected.
2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3. Treatment whose sole purpose is vocationally- or recreationally-based.
4. Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily for maintaining the member's or anyone else's safety.
    b. Could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6. Services rendered by a parent, legal guardian, or legally responsible person.
7. Services that are not evidence-based behavioral intervention practices.

F. The approved behavioral treatment plan must meet the following criteria:

1. Be developed by a BHT Service Provider for the specific member being treated.
2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.

5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
13. Include an exit plan/ criteria.

G. Continuity of care:

1. The Alliance must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services.
2. At least 45 days prior to the transition date, DHCS will provide the Alliance with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members.
3. The Alliance will utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary.
4. The Alliance must make a good faith effort to proactively contact the provider to begin the continuity of care process.
5. The Alliance must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:

a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the Alliance or the date of the member's initial enrollment in the Alliance if enrollment occurred on or after July 1, 2018.

b. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.

c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance's network.

d. The provider is a California State Plan approved provider.

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

6. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance must assign the member to that provider to continue BHT services.
7. BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Alliance provider.
8. If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the Alliance, the Alliance must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the Alliance approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, the Alliance must conduct an Outbound Call Campaign, as described below.

A. Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
B. Make five call attempts to reach the member (or his/her parent/guardian).
C. Inform the member of the transition and the continuity of care process.
D. Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

The Alliance will report metrics to DHCS related to the requirements in a manner determined by DHCS.

DELEGATION OVERSIGHT: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services: Services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or other condition that must be provided to an Alliance member under 21 years of age.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-019 Delegation Oversight

REVISION HISTORY

1/1/2008, 10/28/2009, 4/1/2011, 8/30/2012, 01/10/2016, 12/15/2016, 7/19/2018, 8/3/2018, 09/06/2018, 11/21/2019, 7/31/20, 9/17/2020, 03/22/2022, 12/19/2023, 10/25/24

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Title 42, Section 1396d(R)(5)
Welfare and Institutions Code, CCR, Section 14132.44
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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC)~~Healthcare Quality Committee~~ annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-023
Policy Name	Communicable Disease Reporting and Services
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	10/12/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. Alliance requires that health care practitioners follow all applicable Federal, State, and local statutes, regulations, or ordinances for the reporting of communicable diseases, and to implement directives from public health authorities. Practitionersor Providers must ensure that any Member with a reportable communicable disease is reported to public health authorities according to the appropriate statutes, regulations. or ordinances

B. Failure to report communicable diseases as required by statute, regulation or ordinance can result in negative action taken by the Medical Board of California or Alliance as circumstances warrant.

C. Providers are informed of directives from public health authorities, including their responsibilities for reporting communicable diseases in the Provider Manual. As new directives, including reporting communicable disease are received from public health authorities, Providers will be informed of the new requirements through communication with their offices and the new requirements will be added to the Provider Manual.

D. PCPs are required to:

1. Perform skin testing for tuberculosis (TB) based on the most recent recommended guidelines from the Centers for Disease Control and Prevention (CDC) 'Core Curriculum on Tuberculosis', the American Thoracic Society (ATC) and/or the at-risk status of the Member. Copies of the CDC's curriculum can be downloaded from the Internet through the CDC web page at www.cdc.gov. California TB Control Guidelines are available through the California Tuberculosis Controllers Association's (CTCA) webpage: www.ctca.org.
2. Perform the initial diagnostic work-up for TB based on the latest recommended guidelines by the CDC guidelines "Core Curriculum on Tuberculosis".
3. Report all confirmed or suspected active TB cases to the Local Health Department

(LHD).

4. Treat, diagnose, and coordinate care for Members with confirmed or suspected active TB.
5. Hospitals are required to report any Member with active TB admitted to an inpatient unit to the Alliance by the next normal business day (Monday-Friday).

E. AAH provides all medically necessary covered services to members with TB while on Direct Observed Therapy (DOT)

PROCEDURE

A. The date of public health authority contact, name of contact, and signature of contacting person is documented in the medical record. Reporting is conducted in accordance with the following:

1. State law requires that health care practitioners report specified communicable diseases. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other people knowing of a case or suspected case of any of the diseases or conditions listed in Section C are required to report them to the local Department of Health. (California Administrative Code, Title 17, Sections 2500, 2502, 2503, 2504, 2505 and 2508).
2. Animal bites by a species susceptible to rabies are reportable in order to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals are identified and may be controlled by this regulation and local ordinances (California Administration Code, Title 17, Sections 2606 et seq., and California Health and Safety Code sections 1900-2000). Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing your report.

Alameda County Animal Control Sites	
Alameda City Animal Services Phone: 510-337-8565 https://www.alamedaca.gov/Departments/Animal-Services	**Berkeley Animal Care Services** Phone: 510-981-6600 http://www.ci.berkeley.ca.us/animalservices
Dublin Animal Shelter Phone: (925) 803-7040 https://dublin.ca.gov/113/Animal-Control	**Fremont, Newark, Union City, San Leandro: Tri-City Animal Shelter** Phone: (510) 790-6630 https://www.fremontpolice.gov/about-us/administrative-operations-division/animal-
Hayward Animal Services Phone: (510) 293-7200 https://www.hayward-ca.gov/police-department/public-services/animal-services	**Oakland Animal Services** Phone: (510) 535-5602 http://www.oaklandanimalservices.org/services

B. Providers and practitioners must use the following guidelines for Public Health reporting:

1. Extremely Urgent Conditions (*) - should be reported immediately by telephone, 24 hours a day, to the after-hour emergency number listed below.
2. Other Urgent Conditions (+) - should be reported by telephoning, mailing, or electronically submitting a report within one (1) working day of identification of case or suspected case.
3. All Other Non-Urgent Conditions may be reported by phone or by mail on confidential morbidity report cards within seven (7) days of identification.

C. Local Health Departments (LHD) are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials. In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to your LHD.

D. Investigations of reportable communicable diseases by Local or State Health Departments (source case/case contact follow-up investigations) are exempt from HIPAA regulation and all information requests shall be provided. No patient consent for release of information is needed.

Alameda County Public Health Department

Division of Communicable Disease Control & Prevention
1100 San Leandro Boulevard, San Leandro, CA 94577Phone: (510) 267-3250 (M-F, 8-5)
Phone: (925) 422-7595 (After hours, Weekends)
Website: http://www.acphd.org/,
A-Z Listing: Communicable Disease Control & Prevention

Alameda County Public Health Department

Tuberculosis Control Program
Phone: (510) 667-3096
www.acphd.org/**tb**/**tb-control**.aspx
A-Z Listing: Tuberculosis Control Program – (Clinicians)

Guidelines for TB Diagnosis and Treatment

Alliance Providers are required to follow the most current TB diagnostic and treatment guidelines recommended by the CDC "Core Curriculum on Tuberculosis".

Screening for TB Infection

- For Members ages 0 to 21 years of age, an assessment for risk factors for developing TB and a TB skin test must be provided in compliance with American Academy of Pediatrics (AAP), American Thoracic Society, and Centers for Disease Control and Prevention guidelines and must be provided within 120 days of enrollment with the Alliance. Members are screened for risk of exposure to TB at each subsequent health assessment visit, thereafter.
- For adult Members, an assessment of risk for developing TB is performed as part of the Initial Health Assessment, required within 120 days of enrollment into the Alliance

according to American Thoracic Society, and Centers for Disease Control and Prevention. All Alliance Members with an increased risk of TB are offered TB testing unless they have documentation of prior positive test results or TB disease.

- The Alliance requires PCPs to use the Mantoux tuberculin test screen for TB and/or QuantiFERON test when it becomes readily available. In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN or PA may read the skin test results. Per Title 16, CCR, Sections 2880-2884 and 1366 (b) (2), the Licensed Vocational Nurse (LVN) and the Medical Assistant (MA) are not legally authorized to perform independent analysis, interpretation, and evaluation of data; this regulation applies to the interpretation of TB test results. The LVN and MA are permitted to measure and record the results in millimeters in the Member's medical record, and report findings to the Provider.
- Members who test positive on the Mantoux skin test and have no evidence of active TB on chest x-ray and/or symptom review, must be evaluated for TB preventive therapy and treated, if appropriate, per CDC guidelines "Core Curriculum on Tuberculosis".

Diagnosis of Active Tuberculosis

- PCPs are required to initiate the diagnostic work-up for Members suspected of having active TB. Diagnostic workups should be performed per the latest CDC guidelines "Core Curriculum on Tuberculosis".
- Potential cases of active TB can include PPD positive individuals (unless infected with HIV or are otherwise immunocompromised) with the following signs, symptoms, or findings:
  1. Abnormal chest x-ray not typical for pneumonia, particularly upper lobe disease;
  2. Bronchitis or pneumonia unresponsive to antibiotics;
  3. Persistent unexplained constitutional symptoms such as unexplained weight loss, fever, drenching night sweats;
  4. Hemoptysis; or
  5. Persistent productive cough $\geq$ 3 weeks not due to asthma, bronchitis, or pneumonia.
- The diagnostic evaluation for potential active TB can include the following:
  1. Chest x-ray, including lordotic views;
  2. Sputum smear for mycobacteria;

3. Sputum culture for mycobacteria and anti-TB drug sensitivity testing;
4. Bronchoscopy with biopsy, washings, smear and/or culture;
5. Chest CT scan; and
6. Lymph node or other TB-suspect biopsy sent for pathologic diagnosis and mycobacterium TB.

- PCPs are required to refer all confirmed (class III) or highly suspected (class V) active TB cases, pulmonary or extra pulmonary, to the LHD in Alameda County. The cases must be reported on the same day of suspicion or diagnosis, by phone. A phone call must be made to the appropriate Tuberculosis Program (See page 6).:
- PCPs are required to cooperate with any request from the LHD for medical records, diagnostic test results, and any other pertinent clinical, case contact, or administrative information

Case Management

- PCPs are required to inform their Delegated Medical Group or the Alliance's Medical Services staff of any Member referred to the LHD Tuberculosis Program for active or highly suspected active TB.
- Alliance staff, with LHD Tuberculosis Program collaboration, must identify and address barriers to patient compliance with self-administered treatment. To improve adherence, The Alliance's formulary offers fixed-dose combination drug preparations.
- Alliance Medical Services staff coordinates care for Members who have active TB and other co-morbid medical conditions.

Direct Observed Therapy

- Direct Observed Therapy (DOT) for the treatment of Tuberculosis is provided by the LHD and is not covered by the Alliance.
- PCPs must assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy.

  The following groups of individuals are at risk for non-compliance for treatment of TB:

  1. Members with any demonstrated drug resistance (especially multiple drug resistance to Isoniazid and Rifampin);
  2. Members whose treatment has failed or who have relapsed after completing a prior regimen;
  3. Children and Adolescents;
  4. Members with substance abuse or psychiatric diagnoses; and
  5. Members who have demonstrated non-compliance (those who failed to keep office appointments).
  6. The following groups of Members also must be monitored for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.
- PCPs must inform the LHD's TB Control Program of Members with active TB and who have any of these risks.

- For Members receiving treatment for TB disease, the PCPs must share clinical information with the LHD's TB Control Program as needed and requested.
- The PCP must promptly notify the LHD TB Control Program of any significant changes in the Member's condition, failure to keep appointments, decision to discontinue medications, change in address, or response to medical treatment including adverse drug reactions and dosage changes.
- The Alliance provides all medically necessary medication for Members with TB, via the contracted pharmacies.
- AAH provides all medically necessary covered services to members with TB while they are on DOT.

Hospital Transfers and Discharge

- Hospital infection control staff, including the attending physician, are required to submit a hospital discharge plan to the LHD for approval prior to discharge or transfer of an inpatient case of active TB, per California Health and Safety Code, Section 121361. No patient will be discharged or transferred, unless the transfer is necessary for medical/surgical emergencies, without prior written approval of the LHD.
- Hospital personnel must use the required form provided by the LHD. This form is available online.

Reporting

- Alliance Providers are required to comply with all State laws and regulations pertaining to reporting of confirmed and suspected TB cases to the LHD. Alliance Providers must report known or suspected cases of TB to the LHD TB control programs within one day of identification per Title 17, CCR, Section 2500 (see Policy 10K, "Reporting Communicable Diseases to Public Health Authorities").
- The local health officer may, per State law, require Alliance practitioners at any time to report any clinical information deemed necessary by the local health officer to protect the Member's health or the health of the public.

Contact Investigation and Treatment

- The Alliance requires that all PCPs and Delegated Medical Groups cooperate with the LHD in conducting contact and outbreak investigations potentially involving Members. The Alliance is available to facilitate and if necessary, direct the coordination efforts between the LHD and Alliance PCPs and Delegated Medical Groups. The Alliance requires PCPs and Delegated Medical Groups to provide appropriate examination and treatment to Members identified by the LHD as contacts in a timely manner (usually within seven days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner. The Alliance coordinates with PCP and the Delegated Medical Groups to promptly notify the LHD Tuberculosis Program staff when contacts of Members are referred to the LHD Tuberculosis Program staff for care.

Laboratory Services

- Sputum smears and cultures must be obtained from Members with pulmonary TB at least monthly until culture results are documented negative for two consecutive months.

Delegation Oversight

- The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management

responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None.

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 10/25/24

REFERENCES

1. California Health and Safety Code, Sections 1900-2000
2. DHCS Contract Exhibit A, Attachment 10.5.C and E; 10. 6. C and 8. F; 11.14 and16; and 12. 2
3. Title 17, CCR, Sections 2500, 2502, 2503, 2504, 2505 and 2508

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-023
Policy Name	Communicable Disease Reporting and Services
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	10/12/2006
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~8/18/2023~~
Compliance Committee Approval Date	TBD~~9/18/2023~~

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POLICY STATEMENT

A. Alliance requires that health care practitioners follow all applicable Federal, State, and local statutes, regulations, or ordinances for the reporting of communicable diseases, and to implement directives from public health authorities. Practitionersor Providers must ensure that any Member with a reportable communicable disease is reported to public health authorities according to the appropriate statutes, regulations. or ordinances

B. Failure to report communicable diseases as required by statute, regulation or ordinance can result in negative action taken by the Medical Board of California or Alliance as circumstances warrant.

C. Providers are informed of directives from public health authorities, including their responsibilities for reporting communicable diseases in the Provider Manual. As new directives, including reporting communicable disease are received from public health authorities, Providers will be informed of the new requirements through communication with their offices and the new requirements will be added to the Provider Manual.

D. PCPs are required to:

1. Perform skin testing for tuberculosis (TB) based on the most recent recommended guidelines from the Centers for Disease Control and Prevention (CDC) 'Core Curriculum on Tuberculosis', the American Thoracic Society (ATC) and/or the at-risk status of the Member. Copies of the CDC's curriculum can be downloaded from the Internet through the CDC web page at www.cdc.gov. California TB Control Guidelines are available through the California Tuberculosis Controllers Association's (CTCA) webpage: www.ctca.org.

2. Perform the initial diagnostic work-up for TB based on the latest recommended guidelines by the CDC guidelines “Core Curriculum on Tuberculosis”.

3. Report all confirmed or suspected active TB cases to the Local Health Department (LHD).
4. Treat, diagnose, and coordinate care for Members with confirmed or suspected active TB.
5. Hospitals are required to report any Member with active TB admitted to an inpatient unit to the Alliance by the next normal business day (Monday-Friday).

E. AAH provides all medically necessary covered services to members with TB while on Direct Observed Therapy (DOT)

PROCEDURE

A. The date of public health authority contact, name of contact, and signature of contacting person is documented in the medical record. Reporting is conducted in accordance with the following:

1. State law requires that health care practitioners report specified communicable diseases. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other people knowing of a case or suspected case of any of the diseases or conditions listed in Section C are required to report them to the local Department of Health. (California Administrative Code, Title 17, Sections 2500, 2502, 2503, 2504, 2505 and 2508).
2. Animal bites by a species susceptible to rabies are reportable in order to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals are identified and may be controlled by this regulation and local ordinances (California Administration Code, Title 17, Sections 2606 et seq., and California Health and Safety Code sections 1900-2000). Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing your report.

Alameda County Animal Control Sites	
Alameda City Animal Services Phone: 510-337-8565 https://www.alamedaca.gov/Departments/Animal-Services	**Berkeley Animal Care Services** Phone: 510-981-6600 http://www.ci.berkeley.ca.us/animalservices
Dublin Animal Shelter Phone: (925) 803-7040 https://dublin.ca.gov/113/Animal-Control	**Fremont, Newark, Union City, San Leandro: Tri-City Animal Shelter** Phone: (510) 790-6630 https://www.fremontpolice.gov/about-us/administrative-operations-division/animal-
Hayward Animal Services Phone: (510) 293-7200 https://www.hayward-ca.gov/police-department/public-services/animal-services	**Oakland Animal Services** Phone: (510) 535-5602 http://www.oaklandanimalservices.org/services

B. Providers and practitioners must use the following guidelines for Public Health reporting:

1. Extremely UUrgent Conditions (*) - should be reported immediately by telephone, 24 hours a day, to the after-hour emergency number listed below.
2. Other UUrgent Conditions (+) - should be reported by telephoning, mailing, or electronically submitting a report within one (1) working day of identification of case or suspected case.
3. All Other Non-UUrgent Conditions may be reported by phone or by mail on confidential morbidity report cards within seven (7) days of identification.

~~C. State law requires that practitioners report communicable and non-communicable diseases. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other persons knowing of a CASE OR SUSPECTED CASE of diseases or conditions are required to report them to the local Department of Health (California Administrative Code, Title 17, Sections 2500, 2502, 2503, 2504, 2505 and 2508).~~

~~D.~~C. Local Health Departments (LHD) are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials. In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to your LHD.

~~E.~~D. Investigations of reportable communicable diseases by Local or State Health Departments (source case/case contact follow-up investigations) are exempt from HIPAA regulation and all information requests shall be provided. No patient consent for release of information is needed.

Alameda County Public Health Department

Division of Communicable Disease Control & Prevention
1100 San Leandro Boulevard, San Leandro, CA 94577Phone: (510) 267-3250 (M-F, 8-5)
Phone: (925) 422-7595 (After hours, Weekends)
Website: http://www.acphd.org/,
A-Z Listing: Communicable Disease Control & Prevention

Alameda County Public Health Department

Tuberculosis Control Program
Phone: (510) 667-3096
www.acphd.org/**tb**/**tb-control**.aspx
A-Z Listing: Tuberculosis Control Program – (Clinicians)

Guidelines for TB Diagnosis and Treatment

Alliance Providers are required to follow the most current TB diagnostic and treatment guidelines recommended by the CDC "Core Curriculum on Tuberculosis".

Screening for TB Infection

- For Members ages 0 to 21 years of age, an assessment for risk factors for developing TB and a TB skin test must be provided in compliance with American Academy of Pediatrics (AAP), American Thoracic Society, and Centers for Disease Control and Prevention guidelines and must be provided within 120 days of enrollment with the Alliance. Members are screened for risk of exposure to TB at each subsequent health assessment visit, thereafter.
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- The Alliance requires PCPs to use the Mantoux tuberculin test screen for TB and/or QuantiFERON test when it becomes readily available. In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN or PA may read the skin test results. Per Title 16, CCR, Sections 2880-2884 and 1366 (b) (2), the Licensed Vocational Nurse (LVN) and the Medical Assistant (MA) are not legally authorized to perform independent analysis, interpretation, and evaluation of data; this regulation applies to the interpretation of TB test results. The LVN and MA are permitted to measure and record the results in millimeters in the Member's medical record, and report findings to the Provider.
- Members who test positive on the Mantoux skin test and have no evidence of active TB on chest x-ray and/or symptom review, must be evaluated for TB preventive therapy and treated, if appropriate, per CDC guidelines "Core Curriculum on Tuberculosis".

Diagnosis of Active Tuberculosis

- PCPs are required to initiate the diagnostic work-up for Members suspected of having active TB. Diagnostic workups should be performed per the latest CDC guidelines "Core Curriculum on Tuberculosis".
- Potential cases of active TB can include PPD positive individuals (unless infected with HIV or are otherwise immunocompromised) with the following signs, symptoms, or findings:
  1. Abnormal chest x-ray not typical for pneumonia, particularly upper lobe disease;
  2. Bronchitis or pneumonia unresponsive to antibiotics;
  3. Persistent unexplained constitutional symptoms such as unexplained weight loss, fever, ~~drenchingnight~~ drenching night sweats;
  4. Hemoptysis; or
  5. Persistent productive cough≥ 3 weeks not due to asthma, bronchitis, or pneumonia.
- The diagnostic evaluation for potential active TB can include the following:
  1. Chest x-ray, including lordotic views;
  2. Sputum smear for mycobacteria;

3. Sputum culture for mycobacteria and anti-TB drug sensitivity testing;
4. Bronchoscopy with biopsy, washings, smear and/or culture;
5. Chest CT scan; and
6. Lymph node or other TB-suspect biopsy sent for pathologic diagnosis and mycobacterium TB.

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- PCPs are required to cooperate with any request from the LHD for medical records, diagnostic test results, and any other pertinent clinical, case contact, or administrative information

Case Management

- PCPs are required to inform their Delegated Medical Group or the Alliance's Medical Services staff of any Member referred to the LHD Tuberculosis Program for active or highly suspected active TB.
- Alliance staff, with LHD Tuberculosis Program collaboration, must identify and address barriers to patient compliance with self-administered treatment. To improve adherence, The Alliance's formulary offers fixed-dose combination drug preparations.
- Alliance Medical Services staff coordinates care for Members who have active TB and other co-morbid medical conditions.

Direct Observed Therapy

- Direct Observed Therapy (DOT) for the treatment of Tuberculosis is provided by the LHD and is not covered by the Alliance.
- PCPs must assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy.

  The following groups of individuals are at risk for non-compliance for treatment of TB:

  1. Members with any demonstrated drug resistance (especially multiple drug resistance to Isoniazid and Rifampin);
  2. Members whose treatment has failed or who have relapsed after completing a prior regimen;
  3. Children and Adolescents;
  4. Members with substance abuse or psychiatric diagnoses; and
  5. Members who have demonstrated non-compliance (those who failed to keep office appointments).
  6. The following groups of Members also must be monitored for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.
- PCPs must inform the LHD's TB Control Program of Members with active TB and who have any of these risks.

- For Members receiving treatment for TB disease, the PCPs must share clinical information with the LHD's TB Control Program as needed and requested.
- The PCP must promptly notify the LHD TB Control Program of any significant changes in the Member's condition, failure to keep appointments, decision to discontinue medications, change in address, or response to medical treatment including adverse drug reactions and dosage changes.
- The Alliance provides all medically necessary medication for Members with TB, via the contracted pharmacies.
- AAH provides all medically necessary covered services to members with TB while they are on DOT.

Hospital Transfers and Discharge

- Hospital infection control staff, including the attending physician, are required to submit a hospital discharge plan to the LHD for approval prior to discharge or transfer of an inpatient case of active TB, per California Health and Safety Code, Section 121361. No patient will be discharged or transferred, unless the transfer is necessary for medical/surgical emergencies, without prior written approval of the LHD.
- Hospital personnel must use the required form provided by the LHD. This form is available online.

Reporting

- Alliance Providers are required to comply with all State laws and regulations pertaining to reporting of confirmed and suspected TB cases to the LHD. Alliance Providers must report known or suspected cases of TB to the LHD TB control programs within one day of identification per Title 17, CCR, Section 2500 (see Policy 10K, "Reporting Communicable Diseases to Public Health Authorities").
- The local health officer may, per State law, require Alliance practitioners at any time to report any clinical information deemed necessary by the local health officer to protect the Member's health or the health of the public.

Contact Investigation and Treatment

- The Alliance requires that all PCPs and Delegated Medical Groups cooperate with the LHD in conducting contact and outbreak investigations potentially involving Members. The Alliance is available to facilitate and if necessary, direct the coordination efforts between the LHD and Alliance PCPs and Delegated Medical Groups. The Alliance requires PCPs and Delegated Medical Groups to provide appropriate examination and treatment to Members identified by the LHD as contacts in a timely manner (usually within seven days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner. The Alliance coordinates with PCP and the Delegated Medical Groups to promptly notify the LHD Tuberculosis Program staff when contacts of Members are referred to the LHD Tuberculosis Program staff for care.

Laboratory Services

- Sputum smears and cultures must be obtained from Members with pulmonary TB at least monthly until culture results are documented negative for two consecutive months.

Delegation Oversight

- The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management

responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None.

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 10/25/24

REFERENCES

~~1. Title 17, CCR, Sections 2500, 2502, 2503, 2504, 2505 and 2508~~

~~2.~~ 1. California Health and Safety Code, Sections 1900-2000

~~3.~~2. DHCS Contract Exhibit A, Attachment 10.5.C and E; 10. 6. C and 8. F; 11.14 and16; and 12. 2

3. Title 17, CCR, Sections 2500, 2502, 2503, 2504, 2505 and 2508

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MONITORING

The Compliance and U~~u~~tilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC)~~Healthcare Quality Committee~~ annually.

POLICY AND PROCEDURE

Policy Number	UM-030
Policy Name	Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~8/18/2023~~
Compliance Committee Approval Date	TBD~~9/18/2023~~

POLICY STATEMENT

Alliance PCP, Obstetrical (OB), and Pediatric practitioners must inform Members of the availability of WIC services and make appropriate referrals to the local WIC program for their assigned Members who are potentially eligible for WIC services.
The Alliance maintains a Memorandum of Understanding (MOU) with Alameda County that includes referrals into the WIC program as required in DHCS Contract Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) that ensure closed loop referrals. AAH maintains procedures to identify and refer eligible Members for WIC services. As part of the referral process, AAH ensures the provision to the WIC program of the Member's current hemoglobin or hematocrit laboratory value. AAH also ensures the documentation of the laboratory values and of the referral in the Member's Medical Record.
AAH ensures the referral, and documentation of the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

PROCEDURE

A. Identification:

1. The WIC program provides nutrition assessment, education and counseling to participants, coupons for supplemental foods from WIC authorized vendors, and links participants to community resources. WIC works in collaboration with the participant's medical practitioner and encourages ongoing and preventive care.

2. WIC participants must meet the following eligibility criteria:

   a. Pregnant, breastfeeding up to one year, post-partum non-breastfeeding up to 6 months ~~or a~~

   ~~a.~~ Cehild from birth to ~~under the~~ age of five

   b. Meet income guidelines

   c. Live in a local agency's service area

   d. Determined to be at nutritional risk by a health professional

   e. Receive regular medical assessments

3. Members receive information regarding availability of the WIC Program through the following methods:

   a. OB, pediatrician, or other PCP

   b. Alliance Member Services Department

   c. Member Newsletter

4. Providers must identify pregnant, breastfeeding, and postpartum women, as well as children under the age of five, who would benefit from participating in the WIC program as part of the Initial Health Assessment (IHA) of Members, or, as part of the initial evaluation of newly pregnant women.

   a. They must also, no less than annually provide written notice of the availability of WIC, benefits including the location and telephone number of the local WIC agency, or instructions on how to obtain more information.

   b. Providers must provide all members who are blind, deaf or need the documents available in another language with alternative access to the information.

~~4.~~

B. Referral:

1. Each county WIC program can provide OBs, pediatricians, and other PCPs with WIC informational brochures, and educational materials for Members.

2. OBs, pediatricians, and other PCPs assist Members in applying for WIC by providing referral numbers to WIC centers and the required documentation, including:

   a. Height and weight

   b. Identified nutritional risk factors

   c. Estimated date of delivery for pregnant women

   d. Growth assessment for infants and children

   e. Results of hemoglobin or hematocrit laboratory tests

   f. Identification of any high-risk condition

   g. Diagnosed clinical conditions as appropriate

   h. Physical/medical, biochemical, and anthropometric data

   i. Medical justification for members requiring special therapeutic formula which

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is not a WIC contract formula.

3. Such documentation can be provided to the patient for submission to WIC on the ~~CHDP Form PM 160, the~~ WIC referral form, (PM 247 or PM 247A), the physician's prescription pad, or other reporting forms commonly used by the PCP.
4. The referring practitioner must document the WIC referral in the member's medical record.
5. If required, the referring practitioner must provide additional laboratory test results or other data to the WIC program.
6. Members must apply for WIC services directly and meet eligibility requirements.
7. Program Sites – A list of WIC program sites in Alameda County can be found on the California State WIC Branch's website.

~~7.~~

WIC Program Sites

California State WIC Branch Phone: (888) 942-9675
http://www.cdph.ca.gov/Programs/CFH/DWICS N

Alameda County Healthcare Services Agency - WIC Program Phone: (510) 595-6400
Participant Information/Appointments
Phone: (510) 595-6464 Provider Information Serving all areas of Alameda County
Offices at most community clinics and at the City of Berkeley Public Health Department

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C. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP- 019 Monitoring of Delegation Oversight

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/28/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 08/28/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 11, Provision 17
DHCS Contract Exhibit A, Attachment III, section 2.2.10 and section 4.3.20
Title 42 Chapter IV Subchapter C Part 431 Subpart M 431.635

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare ~~The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.~~

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POLICY AND PROCEDURE

Policy Number	UM-030
Policy Name	Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~8/18/2023~~
Compliance Committee Approval Date	TBD~~9/18/2023~~

POLICY STATEMENT

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AAH ensures the referral, and documentation of the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.

PROCEDURE

A. Identification:

1. The WIC program provides nutrition assessment, education and counseling to participants, coupons for supplemental foods from WIC authorized vendors, and links participants to community resources. WIC works in collaboration with the participant's medical practitioner and encourages ongoing and preventive care.

2. WIC participants must meet the following eligibility criteria:

   a. Pregnant, breastfeeding up to one year, post-partum non-breastfeeding up to 6 months ~~or a~~

   ~~a.~~ Cehild from birth to ~~under the~~ age of five

   b. Meet income guidelines

   c. Live in a local agency's service area

   d. Determined to be at nutritional risk by a health professional

   e. Receive regular medical assessments

3. Members receive information regarding availability of the WIC Program through the following methods:

   a. OB, pediatrician, or other PCP

   b. Alliance Member Services Department

   c. Member Newsletter

4. Providers must identify pregnant, breastfeeding, and postpartum women, as well as children under the age of five, who would benefit from participating in the WIC program as part of the Initial Health Assessment (IHA) of Members, or, as part of the initial evaluation of newly pregnant women.

   a. They must also, no less than annually provide written notice of the availability of WIC, benefits including the location and telephone number of the local WIC agency, or instructions on how to obtain more information.

   b. Providers must provide all members who are blind, deaf or need the documents available in another language with alternative access to the information.

~~4.~~

B. Referral:

1. Each county WIC program can provide OBs, pediatricians, and other PCPs with WIC informational brochures, and educational materials for Members.

2. OBs, pediatricians, and other PCPs assist Members in applying for WIC by providing referral numbers to WIC centers and the required documentation, including:

   a. Height and weight

   b. Identified nutritional risk factors

   c. Estimated date of delivery for pregnant women

   d. Growth assessment for infants and children

   e. Results of hemoglobin or hematocrit laboratory tests

   f. Identification of any high-risk condition

   g. Diagnosed clinical conditions as appropriate

   h. Physical/medical, biochemical, and anthropometric data

   i. Medical justification for members requiring special therapeutic formula which

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is not a WIC contract formula.

3. Such documentation can be provided to the patient for submission to WIC on the ~~CHDP Form PM 160, the~~ WIC referral form, (PM 247 or PM 247A), the physician's prescription pad, or other reporting forms commonly used by the PCP.
4. The referring practitioner must document the WIC referral in the member's medical record.
5. If required, the referring practitioner must provide additional laboratory test results or other data to the WIC program.
6. Members must apply for WIC services directly and meet eligibility requirements.
7. Program Sites – A list of WIC program sites in Alameda County can be found on the California State WIC Branch's website.

~~7.~~

WIC Program Sites

California State WIC Branch Phone: (888) 942-9675
http://www.cdph.ca.gov/Programs/CFH/DWICS N

Alameda County Healthcare Services Agency - WIC Program Phone: (510) 595-6400
Participant Information/Appointments
Phone: (510) 595-6464 Provider Information Serving all areas of Alameda County
Offices at most community clinics and at the City of Berkeley Public Health Department

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C. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP- 019 Monitoring of Delegation Oversight

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/28/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 08/28/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 11, Provision 17
DHCS Contract Exhibit A, Attachment III, section 2.2.10 and section 4.3.20
Title 42 Chapter IV Subchapter C Part 431 Subpart M 431.635

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare ~~The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.~~

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ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-035
Policy Name	Care Coordination – Vision Services
Department Name	Medical Services
Department Owner	Medical Director
Lines of Business	Medi-Cal and Group Care
Effective Date	01/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. PCPs are required to perform vision screening examinations as part of the initial health assessment and as part of specified other physical examinations such as the Bright Futures/ American Academy of Pediatric Preventive Pediatric Health Care.

B. PCPs are responsible for referring Members to vision specialists for care on a routine basis following evidenced based guidelines, school-based screening, or as needed based on results of the vision screening exams

C. PCPs are required to provide covered medical services related to vision services that are not provided by vision specialists. Covered medical services include prescription drugs on the Alliance formulary; laboratory services; and pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a vision procedure.

D. Per APL 23-005 requirements for Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)), vision services are provided at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and include diagnosis and treatment for defects in vision, including eyeglasses.

E. AAH Providers must use the current AAP/ Bright Futures periodicity schedule and guidelines when delivering the Medi-Cal Kids and Teens (EPSDT) benefit, including but not limited to screening services, and vision services.

F. All Alliance members have an ophthalmology benefit and may be referred to an ophthalmologist by their PCP or specialist if the member experiences a medical eye problem.

G. Vision benefits differ based by Line of Business as described in the Explanation of Coverage (EOC) booklet:

1. Medi-Cal EOC_ Section 4 Benefits and Services: Vision Benefits
2. Alliance Group Care EOC Contact Public Authority

PROCEDURE

A. Provider Services Department will educate PCPs and Specialists of their responsibility to provide and document vision services through the Provider Manual and other periodic communication as needed:
   1. As part of the initial health evaluation for new members, PCPs shall conduct a vision screening.
   2. PCPs shall provide routine preventive vision advice.
   3. PCPs shall continue to observe the Member for vision conditions during periodic health examinations for adults and according to the Alliance's Pediatric Preventative Services requirements for children with referrals for treatment as appropriate.
   4. PCPs shall refer to the appropriate vision provider based on the member's plan benefit.
   5. PCPs shall document the results of the vision screening exam in the medical record.
   6. PCPs shall continue to provide all medically necessary health care services to Members even if referred to a vision practitioner for services.

B. Members may call the Alliance Member Service using the number printed in their Explanation of Coverage booklet.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

REVISION HISTORY

10/28/09, 9/20/1, 9/7/12, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 08/28/2024

REFERENCES

MediCal EOC
Alliance Group Care EOC
All Plan Letter 23-005 Requirements for Coverage of EPSDT Services for Medi-Cal Members

Under the Age of 21
DHCS Contract Exhibit A, Attachment 10, Sections 3, 5, 6, and 8.D.
Preventive Care/ Periodicity Schedule (Bright Futures/ AAP), Preventive Care/Periodicity Schedule (aap.org)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-035
Policy Name	Care Coordination – Vision Services
Department Name	Medical Services
Department Owner	Medical Director
Lines of Business	Medi-Cal and Group Care
Effective Date	01/1/2008
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~8/18/2023~~
Compliance Committee Approval Date	TBD~~9/18/2023~~

POLICY STATEMENT

A. PCPs are required to perform vision screening examinations as part of the initial health assessment and as part of specified other physical examinations such as the Bright Futures/ American Academy of Pediatric Preventive Pediatric Health Care.~~-~~

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D. Per APL 23-005 requirements for Medi-Cal for Kids and Teens (also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)~~), (also known as Medi-Cal for Kids and Teens,~~) vision services are provided at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and include diagnosis and treatment for defects in vision, including eyeglasses.

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1. Medi-Cal EOC_ Section 4 Benefits and Services: Vision Benefits
2. Alliance Group Care EOC_ Contact Public Authority

PROCEDURE

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2. PCPs shall provide routine preventive vision advice.
3. PCPs shall continue to observe the Member for vision conditions during periodic health examinations for adults and according to the Alliance's Pediatric Preventative Services requirements for children with referrals for treatment as appropriate.
4. PCPs shall refer to the appropriate vision provider based on the member's plan benefit.
5. PCPs shall document the results of the vision screening exam in the medical record.
6. PCPs shall continue to provide all medically necessary health care services to Members even if referred to a vision practitioner for services.

B. Members may call the Alliance Member Service using the number printed in their Explanation of Coverage booklet.

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DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

REVISION HISTORY

10/28/09, 9/20/1, 9/7/12, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 08/28/2024

REFERENCES

MediCal EOC
Alliance Group Care EOC
All Plan Letter 23-005 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
DHCS Contract Exhibit A, Attachment 10, Sections 3, 5, 6, and 8.D.
Preventive Care/ Periodicity Schedule (Bright Futures/ AAP), Preventive Care/Periodicity Schedule (aap.org)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

PROCEDURE

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2. PCPs shall provide routine preventive vision advice [illegible] examinations for [illegible] conditions during periodic health [illegible] Preventative Services requirements [illegible]

[illegible] members plan benefit. [illegible]

6. PCPs shall continue to provide all medically necessary health care services to Members even if [illegible] Members may call the Alliance Member Service using the number printed in their Explanation of Coverage booklet.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

REVISION HISTORY

10/28/09, 9/20/11, 9/7/12, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 9/18/2023

REFERENCES

Medi-Cal EOC

Alliance Group Care EOC

APL 23-005: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21

DHCS Contract Exhibit A, Attachment 10, Sections 3, 5, 6, and 8.D.

MONITORING

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~~The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.~~

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-047
Policy Name	UM Sub-Committee
Department Name	Health Care Services
Policy Owner	Director Utilization Management
Lines of Business	Medi-Cal and Group Care
Effective Date	10/22/2015
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Utilization Management (UM) Sub-Committee of the Quality Improvement Health Equity Committee (QIHEC) is a forum for the Alliance to evaluate current activities, processes, and metrics internal to the Inpatient and Outpatient UM department. The Sub-Committee also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. The UM Sub-Committee serves multiple purposes:

1) To ensure UM functions meet benchmark standards.
2) To improve quality of care for the Alliance members.
3) To identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.
4) To provide a feedback mechanism to drive quality improvement efforts in Utilization Management.
5) To increase cross functional collaboration and provide accountability across all departments in Health Care Services and other AAH departments.

The Sub-Committee will review and provide feedback regarding utilization trends, specialty referral reports, audit results, opportunities for improvement, and corrective actions plans (CAPs).

PROCEDURE

Committee Composition

The Utilization Management Sub-Committee is chaired by the Chief Medical Officer (CMO) or designee and is composed of Directors and Managers from the following departments:

- Utilization Management
- Compliance
- Quality Assurance/Grievance and Appeals (G&A)
- Quality Improvement
- Pharmacy
- Case Management
- Credentialing
- Member Services
- Provider Relations and Contracting
- Behavioral Health
- Analytics
- Providers contracted with the Alliance (on a as needed basis)

Department	Regular Members
Utilization Management	• CMO • Medical Directors (UM and LTSS) • Senior Director, Health Care Services • UM Director • LTSS Director • UM Managers
Quality Improvement	• Quality Improvement Medical Director • Senior Director, Quality • Appeals and Grievances Manager
Quality Assurance/G&A	• Director, Quality, Accreditation, Audits, Reports and Training
Pharmacy	• Senior Director of Pharmacy
Case Management	• Case Management Medical Director • Director of Social Determinants of Health • CM Managers

*Other subject matter experts from various departments and delegated entities may be asked to attend the UM Sub-Committee meeting which may include: CHCN, CFMG, IT, Compliance, etc.

Governance and Reporting Structure

The Utilization Management Sub-Committee summary reports are reviewed at the Quality Improvement Health Equity Committee (QIHEC) at least once a year:

Committee Operations

1) The Sub-Committee meets at minimum quarterly.
2) A quorum is 50% of the appointed members
3) A simple majority of voting members make decisions.
4) Meeting discussion and actions items are documented in meeting minutes. Approved meeting minutes are reported to HCQC.
5) New deliverables identified in each meeting will be discussed in subsequent meetings.

Responsibilities include, but are not limited to:

1) Review utilization trends to identify over and underutilization for the Alliance Direct, Delegated Medical Groups and Vendors (CHCN, CFMG and CHME). Utilization of services will be compared against benchmark standards (refer to UM-004 Over and Underutilization for process). Areas of focus may include but are not limited to:

    - ER utilization
    - Inpatient admissions and readmissions
    - Radiology services and DME utilization
    - Specialty services and outpatient surgeries
    - Out of Network utilization
    - Pharmacy (retail and specialty injectables)
    - Long-Term Services and Supports (LTSS)
    - CalAIM Community Supports
    - All other services requiring a prior authorization

2) Review reports for overturned denials through the Appeals and Grievance process and evaluates the appropriateness of authorization rules relative to the volume of appeals.
3) Review PCP specialty referral patterns and assess referral performance and issues related to barriers to access. The rate of referrals by specialty will be tracked and evaluated for potential improvement (for process refer to UM-004 Over and Underutilization).
4) Review and monitor corrective action plans and opportunities for improvement for UM processes.
    - Review internal UM audit results conducted by UM.
    - Review Internal UM audit results from Compliance.
    - Review UM CAPs issued by regulatory or accrediting bodies: DHCS, DMHC, NCQA

Change Management Process

If the UM Sub-Committee decides to make any changes or refinements that will impact a specific department, UM will work with the affected stakeholder accordingly. All CAPs and opportunities for improvement will be reported to the Quality Improvement Health Equity Committee (QIHEC).

Any recommended changes from QIHEC will be taken into consideration. Ad Hoc meetings may be called by the CMO during which respective UM Sub-Committee members will review the recommendations made by QIHEC. A decision will be made by the Sub-Committee about implementing the requested change and report back to QIHEC.

DEFINITIONS

None

AFFECTED DEPARTMENTS

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. DHCS Contract Exhibit A, Attachment 4, Section 9.B
2. DHCS Contract Exhibit E, Attachment 2, Section B.1
3. UM-001 UM Program
4. UM-004 Over and Under Utilization
5. UM Program Description

REVISION HISTORY

01/10/2016, 12/15/2016, 5/25/2017, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 9/19/2023, 08/29/2024

REFERENCES

DHCS Contract Exhibit A, Attachment III

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually

POLICY AND PROCEDURE

Policy Number	UM-047
Policy Name	UM Sub-Committee
Department Name	Health Care Services
Policy Owner	~~Medical Director~~Director Utilization Management
Lines of Business	Medi-Cal and Group Care
Effective Date	10/22/2015
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	TBD~~9/18/2023~~

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POLICY STATEMENT

The Utilization Management (UM) Sub-Committee of the Quality Improvement Health Equity Committee (QIHEC) ~~Health Care Quality Committee (HCQC,)~~ is a forum for the Alliance to evaluate current activities, processes, and metrics internal to the Inpatient and Outpatient UM department. The Sub-Committee also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. The UM Sub-Committee serves multiple purposes:

1) To ensure UM functions meet benchmark standards.
2) To improve quality of care for the Alliance members.
3) To identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.
4) To provide a feedback mechanism to drive quality improvement efforts in Utilization Management.
5) To increase cross functional collaboration and provide accountability across all departments in Health Care Services and other AAH departments.

The Sub-Committee will review and provide feedback regarding utilization trends, specialty referral reports, audit results, opportunities for improvement, and corrective actions plans (CAPs).

PROCEDURE

Committee Composition

The Utilization Management Sub-Committee is chaired by the Chief Medical Officer (CMO) or designee and is composed of Directors and Managers from the following departments:

- Utilization Management
- Compliance
- Quality Assurance/Grievance and Appeals (G&A)
- Quality Improvement
- Pharmacy
- Case Management
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- Member Services
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- Providers contracted with the Alliance (on a as needed basis)

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Quality Assurance/G&A	• Director, Quality~~,~~ Accreditation, Audits, Reports and Training
Pharmacy	• Senior Director of Pharmacy
Case Management	• Case Management Medical Director • Director of Social Determinants of Health • CM Managers

*Other subject matter experts from various departments and delegated entities may be asked to attend the UM Sub-Committee meeting which may include: CHCN, CFMG, IT, Compliance, etc.

Governance and Reporting Structure

The Utilization Management Sub-Committee summary reports are reviewed at the Quality Improvement Health Equity Committee (QIHEC) ~~Healthcare Quality Committee (HCQC)~~ at

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least once a year:

Committee Operations

1) The Sub-Committee meets at minimum quarterly.
2) A quorum is 50% of the appointed members
3) A simple majority of voting members make decisions.
4) Meeting discussion and actions items are documented in meeting minutes. Approved meeting minutes are reported to HCQC.
5) New deliverables identified in each meeting will be discussed in subsequent meetings.
~~5)~~

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Responsibilities include, but are not limited to:

1) Review utilization trends to identify over and underutilization for the Alliance Direct, Delegated Medical Groups and Vendors (CHCN, CFMG ~~, Kaiser,~~ and CHME). Utilization of services will be compared against benchmark standards (refer to UM-004 Over and Underutilization for process). Areas of focus may include but are not limited to:

   - ER utilization
   - Inpatient admissions and readmissions
   - Radiology services and DME utilization
   -
   - ~~DME~~
   - Specialty services and outpatient surgeries
   - Out of Network utilization
   - ~~ER admissions~~
   - ~~Inpatient admissions and readmissions~~
   - Pharmacy (retail and specialty injectables)
   - Long-Term Services and Supports (LTSS)
   - CalAIM Community Supports
   - All other services requiring a prior authorization
   -

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2) Review reports for overturned denials through the Appeals and Grievance process and evaluates the appropriateness of authorization rules relative to the volume of appeals.
3) Review PCP specialty referral patterns and assess referral performance and issues related to barriers to access. The rate of referrals by specialty will be tracked and evaluated for potential improvement (for process refer to UM-004 Over and Underutilization).
4) Review and monitor corrective action plans and opportunities for improvement for UM processes.
   - Review internal UM audit results conducted by UM.
   - Review Internal UM audit results from Compliance.
   - Review UM CAPs issued by regulatory or accrediting bodies: DHCS, DMHC, NCQA

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Change Management Process

If the UM Sub-Committee decides to make any changes or refinements that will impact a specific

department, UM will work with the affected stakeholder accordingly. All CAPs and opportunities for improvement will be reported to the Quality Improvement Health Equity Committee (QIHEC). ~~Healthcare Quality Committee (HCQC).~~

Any recommended changes from ~~HCQC~~ QIHEC will be taken into consideration. Ad Hoc meetings may be called by the CMO during which respective UM Sub-Committee members will review the recommendations made by ~~HCQC~~QIHEC. A decision will be made by the Sub-Committee about implementing the requested change and report back to ~~HCQC~~QIHEC.

DEFINITIONS

None

AFFECTED DEPARTMENTS

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. DHCS Contract Exhibit A, Attachment 4, Section 9.B
2. DHCS Contract Exhibit E, Attachment 2, Section B.1
3. UM-001 UM Program
4. UM-004 Over and Under Utilization
5. UM Program Description

REVISION HISTORY

01/10/2016, 12/15/2016, 5/25/2017, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 9/19/2023, 08/29/2024

REFERENCES

DHCS Contract Exhibit A, Attachment III

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually

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POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Medical Services
Policy Owner	Senior Director, Health Care Services
Lines of Business	Medi-Cal, Group Care
Effective Date	11/10/2016
Subcomittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.

POLICY

A. Alameda Alliance maintains current regulatory required timeliness standards for Utilization Review decision making and subsequent notification timeframes of the decision to both the Member and Provider.

1. Regulations, licensure and contractual requirements, and accreditation standards require Utilization Management (UM) decisions (medical and behavioral health) and notifications to be made within required timeframes. When theses required timeframes differ, Alameda Alliance has determined that the strictest standard takes precedence.

2. The attached, "UM Timeliness Standards for MediCal/ Group Care" document shows the timeliness standards specific to Medi-Cal and Group Care and is based on DHCS, DMHC, Health and Safety Code §1367.01, & NCQA Standard UM 5.

3. UM timeliness standards shall apply to all UM decisions whether the decisions are made on the basis of benefit coverage or on medical necessity, and to all UM decisions; approvals (favorable), partially favorable, modifications, denials (adverse), and terminations.

B. Measurement of Timeliness
   1. Counting days for Authorization Requests

a. Day of receipt of request is counted as day zero.
b. Day following day of receipt of request is counted as day one, etc.

2. Counting Hospital Days
   a. Day of admission is counted as day one
   b. Discharge day is not counted.

C. Determining Day of Receipt of a Request for Authorization at AAH
   1. The day of receipt of a request for authorization is when the request is made to Alameda Alliance in accordance with its reasonable filing procedures, regardless of whether Alameda Alliance has all the information necessary to make the decision at the time of the request.

D. Receiving Authorizations During Business Hours and After Business Hours

   1. For requests received during normal business hours by UM phone line, fax, or portal the date/time received is logged as the same the telephone call, fax, or portal submission is received.

   2. Alameda Alliance informs providers, via the provider manual and website that urgent requests submitted after normal business hours should be made by calling UM On-call line 510-326-5271.
      a. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

E. Alameda Alliance has a process for determining urgency (expedited request status)
   1. When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer questions the urgency, the UM Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.
      a. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.

F. Concurrent Review
   1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a care plan has been agreed upon by the treating provider which is appropriate for the medical needs of that patient.

PROCEDURE

A. AAH time frames for processing UM request per attachment grid A:

   1. Performs medical review of authorization requests for covered benefits and Medical Necessity.

   2. Makes utilization decisions within required decision timeframes, but also within a timely manner in order to expedite care to Members.

3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards.

B. The time of receipt of a request for authorization is when the request is made to AAH in accordance with its reasonable filing procedures, regardless of whether AAH has all the information necessary to make the decision at the time of the request.

1. For requests received during normal business hours, the date of receipt is logged as the same day the telephone call, fax, or portal submission is received.

2. For requests received outside of normal business hours by 510-326-5271 line, the date of receipt is logged as the same day the telephone call is received.

3. For requests received by fax or portal that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.

C. Determining whether a Pre-Service Review marked as Urgent (Expedited) meets the definition of Pre-Service Review, Expedited (Urgent)

1. If the Medical Director makes the determination that the request does not meet expedited criteria, then the Medical Director may ask the Nurse reviewer to obtain additional information from the requesting provider to support the decision and /or will attempt to contact the requesting provider via a physician-to-physician phone call.
   a. For those non-supported expedited request then the Medical Director will change the status to routine and the UM Clinical Reviewer will follow notification policy

2. The UM Clinical Reviewer gives the name of the Medical Director and phone number to the requesting physician.

3. When a pre-service request is marked as Urgent (expedited) on the request form, the UM Clinical Reviewer will review for urgency and then refers to Medical Director for final determination in those cases perceived not to be urgent.

4. In those instances where the medical director disagrees with the requesting physician on urgency, a physician-to-physician phone call will be attempted.

D. When a pre-service request for pharmaceuticals (including injectables) is received by FAX or portal in the UM Department, the UM staff Member receiving the submission notifies the Pharmacy staff via the pharmacy group email to enable Pharmacy to complete the pharmaceutical review.

1. Physician Administered Drug reviews follow Pharmacy timeliness requirements (see RX-011 Decision and Notification Requirements)

2. Therapeutic enteral formula reviews follow the medical UM timeliness requirements, (Pre-Service Urgent, Routine, Routine Current, Urgent Concurrent, Delay, Retrospective, etc.), per MMCD Policy letter 12-005 Enteral Feeding.

E. MONITORING

1. The Utilization Management Department, on a routine basis, reviews the results from the monthly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

DEFINITIONS / ACRONYMS

A. **Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider

B. **Department of Health Care Services (DHCS)** is the State agency responsible for administration of the Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP). Child Health and Disabilities Prevention (CHDP) and other health related programs.

C. **Department of Mental Health Care (DMHC)** is the state agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community base public mental health services statewide.

D. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

E. **Member** means any eligible beneficiary who has enrolled in Alameda Alliance for Health or Group Care.

F. **Post Stabilization Care** means Medically Necessary care following stabilization of an Emergency Medical Condition.

G. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

H. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

I. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. It is a formal review of the coverage, Medical Necessity, efficiency, or appropriateness of health care

services, which can be performed on a preservice, concurrent, or post service basis.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department
(UM/ LTSS)
Compliance Department
Pharmacy Department

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal and Group Care

REVISION HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, 02/21/2023, 08/29/2024

REFERENCES

1. Attachment 13 – Member Services, Item 8 (A) through (E)
2. CA Health and Safety Code sections 1367.01(h)(1) through (5)
3. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)
4. MMCD Policy Letter 12-005 Enteral Feedings
5. Title 22 CCR Section 53855 (a) or any future amendments thereto.

POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Medical Services
Policy Owner	Senior Director, Health Care Services
Lines of Business	Medi-Cal, Group Care
Effective Date	11/10/2016
Subcomittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	~~02/21/2023~~TBD

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~~OVERVIEW~~POLICY STATEMENT

Alameda Alliance will meet all applicable state and federal timely ~~decision making~~decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.

POLICY

A. Alameda Alliance maintains current regulatory required timeliness standards for Utilization Review decision making and subsequent notification timeframes of the decision to both the Member and Provider.

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1. Regulations, licensure and contractual requirements, and accreditation standards require Utilization Management (UM) decisions (medical and behavioral health) and notifications to be made within required timeframes. When theses required timeframes differ, Alameda Alliance has determined that the strictest standard takes precedence.

~~1.~~

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2. The attached, "UM Timeliness Standards for MediCal/ Group Care" document shows the timeliness standards specific to Medi-Cal and Group Care and is based on DHCS, DMHC, Health and Safety Code §1367.01, & NCQA Standard UM 5.

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3. UM timeliness standards shall apply to all UM decisions whether the decisions are made on the basis of benefit coverage or on medical necessity, and to all UM decisions; approvals (favorable), partially favorable, modifications, denials (adverse), and terminations.

B. Measurement of Timeliness

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1. Counting days for Authorization Requests

a. Day of receipt of request is counted as day zero.
b. Day following day of receipt of request is counted as day one, etc.

2. Counting Hospital Days
a. Day of admission is counted as day one
~~a.~~b. D~~; d~~ischarge day is not counted.

C. Determining Day of Receipt of a Request for Authorization at AAH
1. The day of receipt of a request for authorization is when the request is made to Alameda Alliance in accordance with its reasonable filing procedures, regardless of whether Alameda Alliance has all the information necessary to make the decision at the time of the request.

D. Receiving Authorizations During Business Hours and After Business Hours

1. For requests received during normal business hours by UM phone line, ~~or~~ fax, or portal the date/time received is logged as the same the telephone call, ~~or~~ fax, or portal submission is received.
~~1.~~

2. Alameda Alliance informs providers, via the provider manual and website that urgent requests submitted ~~submitted~~ after normal business hours should be made by calling UM On-call line 510-326-5271.
~~2.~~
~~3.~~a. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.
~~i.~~

E. Alameda Alliance has a process for determining urgency (expedited request status)
1. When a pre-service request is marked as urgent (expedited) on the request form ~~–~~and the UM Clinical Reviewer questions the urgency, the UM Clinical Reviewer will forward the request to a ~~physician~~ Medical Director reviewer to determine ~~because only a physician can make a determination~~ whether the request is urgent (expedited) or routine, based on the presenting referral information.
a. The Physician Reviewer is the only ~~party~~decision maker than can determine if a request needs to be deescalated from Urgent to Routine.
~~1.~~

~~2. If the physician makes the determination that the request does not meet expedited criteria, the physician ask the Nurse reviewer to obtain additional information from the requesting provider to support and /or will attempt to contact the requesting provider. For those non-supported expedited request UM physician will change the status to routine and the UM Clinical Reviewer will follow notification policy~~

~~3. The UM Clinical Reviewer also gives the name of the physician reviewer and phone number to the requesting physician.~~

F. Concurrent Review
1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a care plan has been agreed upon by the treating provider ~~that~~ which is appropriate for the medical needs of that patient.

PROCEDURE

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A. AAH time frames for processing UM request per attachment grid A:

1. PAAH performs medical review of authorization requests for covered benefits and Medical Necessity ~~and covered benefits~~.
~~1.~~
2. Makes utilization decisions within required decision timeframes, but also within a timely manner in order to expedite care to Members.
~~2.~~
3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards.
~~3.~~

B. The time of receipt of a request for authorization is when the request is made to AAH in accordance with its reasonable filing procedures, regardless of whether AAH has all the information necessary to make the decision at the time of the request.

~~B.~~

~~1. AAH has informed Providers via the Provider manual that urgent requests submitted after normal business hours should be made by calling 510-326-5271.~~

1. For requests received during normal business hours, the date of receipt is logged as the same day the telephone call, ~~or~~ fax, or portal submission is received.
~~2.~~
2. For requests received outside of normal business hours by 510-326-5271 line, the date of receipt is logged as the same day the telephone call is received.
~~3.~~
3. For requests received by fax or portal that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.
~~4.~~

Determining w~~W~~hether a Pre-Service Review marked as Urgent (Expedited) meets the definition of Pre-Service Review, Expedited (Urgent)

C.

1. If the ~~physician~~Medical Director makes the determination that the request does not meet expedited criteria, then the ~~physician~~ Medical Director may ask the Nurse reviewer to obtain additional information from the requesting provider to support the decision and /or will attempt to contact the requesting provider via a physician-to-physician phone call.
a. For those non-supported expedited request ~~UM physician~~then the Medical Director will change the status to routine and the UM Clinical Reviewer will follow notification policy

2. The UM Clinical Reviewer ~~also~~ gives the name of the ~~physician reviewer~~Medical Director and phone number to the requesting physician.

3. When a pre-service request is marked as Urgent (expedited) on the request form, the UM Clinical Reviewer ~~on presenting~~will review for urgency and then refers to ~~physician~~ Medical Director for final determination in those cases perceived not to be urgent.
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4. In those instances where the medical director disagrees with the requesting physician on urgency, a ~~physician to physician~~physician-to-physician phone call will be ~~made~~attempted.

~~6.~~

D. When ~~a~~ a pre-service request for pharmaceuticals (including injectables) is received by FAX or portal in the UM Department, the UM staff Member receiving the ~~FAX~~ submission notifies the Pharmacy staff via the pharmacy group email to enable Pharmacy to ~~C~~complete the pharmaceutical review.

~~C.~~

1. Physician Administered Drug reviews follow Pharmacy timeliness requirements (see RX-011 Decision and Notification Requirements)

~~1.~~

2. Therapeutic enteral formula reviews follow~~s~~ the medical UM timeliness requirements, (Pre-Service Urgent, Routine, Routine Current, Urgent Concurrent, Delay, Retrospective, etc.), per MMCD Policy letter 12-005 Enteral Feeding.

~~2.~~

E. MONITORING

1. The Utilization Management Department, on a routine basis, reviews the results from the monthly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

DEFINITIONS / ACRONYMS

A. **Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider~~.~~

~~A.~~

B. **Department of Health Care Services (DHCS)** is the State agency responsible for administration of the Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP). Child Health and Disabilities Prevention (CHDP) and other health related programs.

~~B.~~

C. **Department of Mental Health Care (DMHC)** is the state agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community base public mental health services statewide.

~~C.~~

D. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

~~D.~~

E. **Member** means any eligible beneficiary who has enrolled in Alameda Alliance for Health or Group Care.

~~E.~~

F. **Post Stabilization Care** means Medically Necessary care following stabilization of an Emergency Medical Condition.

~~F.~~

G. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. NCQA

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considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

~~G.~~

H. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

~~H.~~

I. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. It is a formal review of the coverage, Medical Necessity, efficiency, or appropriateness of health care services, which can be performed on a preservice, concurrent, or post service basis.

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AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department
(UM/ LTSS)
Compliance Department
Pharmacy Department
~~Beacon Health Outcomes~~

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal and Group Care

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~~CMP-019 Delegation Oversight~~

~~RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS~~

~~UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal and Group Care~~

REVISION HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, 02/21/2023, 08/29/2024

REFERENCES

1. Attachment 13 – Member Services, Item 8 (A) through (E)
~~1.~~2. CA Health and Safety Code sections 1367.01(h)(1) through (5)
3. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)
~~2.~~4. MMCD Policy Letter 12-005 Enteral Feedings
~~3. Attachment 13 – Member Services, Item 8 (A) through (E)~~
~~4.~~5. Title 22 CCR Section 53855 (a) or any future amendments thereto.
~~5. MMCD Policy Letter 12-005 Enteral Feedings~~

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-053
Policy Name	Breastfeeding: Lactation Management Aids, Donor Human Breast Milk & Nutrition Services
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	All
Effective Date	08/24/2017
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (The Alliance) is committed to breastfeeding promotion and supports for all Alliance members. Breastfeeding provides many benefits to both the nursing infant and mother, particularly in the postpartum care. Breastfeeding offers health, nutrition, immunological, developmental, economic, psychological, social, and environmental benefits. Per the Centers for Disease Control, breastfeeding or the use of the mother's milk through breast pumping, can protect the infant from developing asthma, obesity, type 1 diabetes, ear infections, gastrointestinal infections, sudden infant death syndrome (SIDS) and necrotizing enterocolitis for preterm infants.

The American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologist (ACOG) recommends exclusive breastfeeding for the baby's first 6 months. Continued breastfeeding is a personal choice and may be influenced by whether the mother and infant both want to continue. The most health benefits are seen when breastfeeding occurs for 2 years or more, while most infants are introduced to complementary foods starting at 6 months of age. To support optimal breastfeeding and resulting health benefits, the Alliance makes lactation management aids (i.e. breast pumps and related durable medical equipment) and other support services available to members. Medically necessary lactation equipment like breast bumps and supplies may be needed to support longevity and

exclusivity of breastfeeding as recommended by the AAP and ACOG.

Reasons for needing a **breast pump and related supplies** may include, but are not limited to, the following:

- A newborn remains in the hospital after the mother is discharged
- Difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.
- A mother develops or has a medical condition that requires treatment of her breast milk before infant feeding, or precludes her from direct nursing at the breast
- Infant illness or disability that interferes with feeding, that may include hospitalization that precludes direct nursing at the breast on a regular basis.
- Infant has a congenital or acquired condition that precludes effective direct nursing at the breast
- Multiple births
- Any maternal illness, disease or use of medication (i.e. chemotherapy agents, or other FDA black box warnings) that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so.
- Physical separation of the mother and baby, including the mother's return to work or school.

Pasteurized Donor Human Breast Milk (PDHM) coverage as of Jan 1, 2023 is a benefit and includes human breast milk processing, storage and distribution from a licensed and approved facility:

- San Jose • Address: Mother's Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112 • Phone: 408 998-4550 • Email: recipient.coordinator@mothersmilk.org • Website: https://mothersmilk.org/

- San Diego • Address: University of California Health Milk Bank 3636 Gateway Center Ave, Suite 102 San Diego, CA 92102 • Phone: 858 249-MILK (6455) • Email: ucmilkbank@health.ucsd.edu • Website: https://health.universityofcalifornia.edu/patient-care/milk-bank

PDHM Criteria:

- A mother is unable to breast feed due to medical conditions;
- The infant cannot tolerate formula or has medical contra-indications to using formulas, including elemental formulas;
- The infant is born at a very low birthweight (less than1500 g) and very premature (less than 32 weeks gestation);
- The infant has a gastrointestinal anomaly, a metabolic/digestive disorder, or is in recovery from an intestinal surgery when digestive needs require additional support;
- The infant is diagnosed with failure to thrive (not appropriately gaining weight/growing);
- The infant has formula intolerance with documented feeding difficulty or weight loss;

- The infant has been diagnosed with hypoglycemia (low blood sugar), congenital heart disease, pre or post organ transplant, or another serious health condition when the use of banked donor human milk is medically necessary and supports the treatment and recovery of the infant; or
- The mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.

This coverage includes 3 ounces per unit, 35 ounces per day, and is only good for 30 days. Coverage may be up to 12 months of age if it is medically necessary and appropriate. Please reference the DHCS Provider Manual, Part 2 – Durable Medical Equipment (DME): Other DME Equipment for further information.

Nutritional counseling services related to breast feeding may be rendered by a physician. Nutrition services that support breast feeding include, but are not limited to:

- Persistent discomfort to the woman while breastfeeding
- Infant weight gain concerns
- Milk extraction
- Suck dysfunctions of the infant

Please reference the DHCS Provider Manual, Part 2 – Pregnancy: Postpartum and Newborn Referral Services for further information.

PROCEDURE

1) The Alliance covers all Lactation Management Aids as described in the most updated version of the DHCS Provider Manual Durable Medical Equipment (DME): Other DME Equipment, Breastfeeding: Lactation Management Aids. This includes breast pumps (manual or electric) and breast pump supplies that can be rented or purchased.

   Either a Provider in the Alliance Network or an Alliance-contracted International Board-Certified Lactation Consultant can request authorization and distribution of Lactation Management Aids.

2) Each type of breast pump is considered a separate type of equipment. Distribution of one type of pump will not preclude the distribution of another pump as long as the authorization request is made by the providers and/or consultants can justify the need for both items that are not duplicates.

3) Lactation management aids can be distributed under either the mother or the child. However, if the mother or child has already received the specified pump, a second pump of the same type will not be distributed to the dyad.

4) Members may request personal grade pumps (E0603) up to one month prior to the

Expected Delivery Date (EDD), but pumps will not be delivered until after birth or if medically necessity is met for other breast-feeding children.

DEFINITIONS / ACRONYMS

- **ACOG** – American College of Obstetricians and Gynecologist
- **APP** - American Academy of Pediatrics
- **DME** – Durable Medical Equipment
- **Pasteurized Donor Human Breast Milk (PDHM)** – breast milk that has been collected from screen donors, heat treated and pooled to make it safe for babies to consume. Donors are screened for medical and lifestyle history, and for use of prescription and nonprescription drug and substances. The milk is pulled from multiple donors and heat treated to kill harmful bacteria and viruses. The milk is frozen and stored until it's ready for use.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Health Education
Quality Improvement
Claims

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management Screening Enrollment and Assessment
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-034 Transitional Care Services
UM-008 Coordination of Care – California Children's Services
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment ((EPSDT)
UM-025 Guidelines for Obstetric Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Breast Pump Authorization Form

REVISION HISTORY

05/20/2021, 05/21/2020, 06/28/2022, 09/19/2023, 09/25/2024

REFERENCES

Bright Futures/ AAP
DHCS Provider Manual: Pregnancy: Postpartum and Newborn Referral Services, and Obstetrics – Medi-Cal.
DHCS MMCD Policy Letter 98-10, Breastfeeding Promotion
Other DME Equipment, Breastfeeding: Lactation Management Aids, August 2021

MONITORING

The Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. This policy will be reviewed for approval by the Alliance's Quality Improvement Health Equity Committee (QIHEC) annually.

POLICY AND PROCEDURE

Policy Number	UM-053
Policy Name	Breastfeeding: Lactation Management Aids, Donor Human Breast Milk & Nutrition Services
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	All
Effective Date	08/24/2017
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (The Alliance) is committed to breastfeeding promotion and supports for all Alliance members. Breastfeeding provides many benefits to both the nursing infant and mother, particularly in the postpartum care. Breastfeeding offers health, nutrition, immunological, developmental, economic, psychological, social, and environmental benefits. Per the Centers for Disease Control, breastfeeding or the use of the mother's milk through breast pumping, can protect the infant from developing asthma, obesity, type 1 diabetes, ear infections, gastrointestinal infections, sudden infant death syndrome (SIDS) and necrotizing enterocolitis for preterm infants.

The American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologist (ACOG) recommends exclusive breastfeeding for the baby's first 6 months. C~~and c~~ontinued breastfeeding is a personal choice and may be influenced by whether the mother and infant both want to continue. The most health benefits are seen when breastfeeding occurs for 2 years or more, while most infants are introduced to complementary foods starting at 6 months of age. ~~up to one year and beyond when desired by both mom and baby.~~ To support optimal breastfeeding and resulting health benefits, the Alliance makes lactation management aids (i.e. breast pumps and related durable medical equipment) and other support services available to members. ~~This includes~~Medically necessary lactation equipment like breast bumps and supplies ~~that is medically necessary as~~

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~~well as~~ may be needed ~~equipment needed~~ to support longevity and exclusivity of breastfeeding as recommended by the ~~the~~ AAP and ACOG.

Reasons for needing a **breast pump and related supplies** may include, but are not limited to, the following:

- A newborn ~~is detained in~~remains in the hospital after the mother is discharged
- Difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.
- A mother develops or has a medical condition that requires treatment of her breast milk before infant feeding, or precludes her from direct nursing at the breast
- Infant illness or disability that interferes with feeding, that may include hospitalization that precludes direct nursing at the breast on a regular basis.
- Infant has a congenital or acquired condition that precludes effective direct nursing at the breast
- ~~Difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.~~
- Multiple births
- Any maternal illness, disease or use of medication (i.e. chemotherapy agents, or other FDA black box warnings) that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so.
- Physical separation of the m~~other~~other ~~om~~ and baby, including the ~~mom's~~mother's return to work or school.

Pasteurized Donor Human Breast Milk (PDHM) coverage as of Jan 1, 2023 is a benefit and includes human breast milk processing, storage and distribution from a licensed and approved facility:

- San Jose • Address: Mother's Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112 • Phone: 408 998-4550 • Email: recipient.coordinator@mothersmilk.org • Website: https://mothersmilk.org/
- San Diego • Address: University of California Health Milk Bank 3636 Gateway Center Ave, Suite 102 San Diego, CA 92102 • Phone: 858 249-MILK (6455) • Email: ucmilkbank@health.ucsd.edu • Website: https://health.universityofcalifornia.edu/patient-care/milk-bank

PDHM Criteria:

- A mother is unable to breast feed due to medical conditions;
- The infant cannot tolerate formula or has medical contra-indications to using formulas, including elemental formulas;
- The infant is born at a very low birthweight (less than1500 g) and very premature (less than 32 weeks gestation);
- The infant has a gastrointestinal anomaly, a metabolic/digestive disorder, or is in recovery

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from an intestinal surgery when digestive needs require additional support;

- The infant is diagnosed with failure to thrive (not appropriately gaining weight/growing);
- The infant has formula intolerance with documented feeding difficulty or weight loss;
- The infant has been diagnosed with hypoglycemia (low blood sugar), congenital heart disease, pre or post organ transplant, or another serious health condition when the use of banked donor human milk is medically necessary and supports the treatment and recovery of the infant; or
- The mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.

This coverage includes 3 ounces per unit, 35 ounces per day, and is only good for 30 days. Coverage may be up to 12 months of age if it is medically necessary and appropriate. Please reference the DHCS Provider Manual, Part 2 – Durable Medical Equipment (DME): Other DME Equipment for further information.

Nutritional counseling services related to breast feeding may be rendered by a physician. Nutrition services that support breast feeding include, but are not limited to:

- Persistent discomfort to the woman while breastfeeding
- Infant weight gain concerns
- Milk extraction
- Suck dysfunctions of the infant

Please reference the DHCS Provider Manual, Part 2 – Pregnancy: Postpartum and Newborn Referral Services for further information.

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PROCEDURE

1) The Alliance covers all Lactation Management Aids as described in the most updated version of the DHCS Provider Manual Durable Medical Equipment (DME): Other DME Equipment, Breastfeeding: Lactation Management Aids~~, August 2021; page 20~~. This includes breast pumps (manual or electric) and breast pump supplies that can be rented or purchased.

~~2)~~ Either a P~~p~~rovider in the Alliance Network or an Alliance-contracted International Board~~-~~ Certified Lactation Consultant can request authorization and distribution of Lactation Management Aids.

~~3)~~2) Each type of breast pump is considered a separate type of equipment. Distribution of one type of pump will not preclude the distribution of another pump as long as the authorization request is made by the providers and/or consultants ~~mentioned in 2.~~can justify the need for both items that are not duplicates.

~~4)~~3) Lactation management aids can be distributed under either the mother or the child. However, if the mother or child has already received the specified pump, a second

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pump of the same type will not be distributed to the dyad.

~~5)~~4) Members may request personal grade pumps (E0603) up to one month prior to the Expected Delivery Date (EDD), but pumps will not be delivered until after birth or if medically necessity is met for other ~~breast feeding~~breast-feeding children.

DEFINITIONS / ACRONYMS

- **ACOG** – American College of Obstetricians and Gynecologist
- **APP** - American Academy of Pediatrics
- **DME** – Durable Medical Equipment
- **Pasteurized Donor Human Breast Milk (PDHM)** – breast milk that has been collected from screen donors, heat treated and pooled to make it safe for babies to consume. Donors are screened for medical and lifestyle history, and for use of prescription and ~~non prescription~~nonprescription drug and substances. The milk is pulled from multiple donors and heat treated to kill harmful bacteria and viruses. The milk is frozen and stored until it's ready for use.

~~**APP** - American Academy of Pediatrics~~

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Health Education
~~Utilization Management~~
Quality Improvement
Claims

~~Quality Improvement~~

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management Screening Enrollment and Assessment
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-034 Transitional Care Services
UM-008 Coordination of Care – California Children's Services
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment ((EPSDT)
UM-025 Guidelines for Obstetric Services

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Breast Pump Authorization Form

REVISION HISTORY

05/20/2021, 05/21/2020, 06/28/2022, 09/19/2023, 09/25/2024

~~**REVISION HISTORY**~~

~~5/20/2021, 5/21/2020, 6/28/2022, 9/19/2023~~
~~5/202021, 5/21/2020, 6/28/2022, 9/19/2023~~

REFERENCES

Bright Futures/ AAP
DHCS Provider Manual: Pregnancy: Postpartum and Newborn Referral Services, and Obstetrics – Medi-Cal.
~~Department of Health Care Services (~~DHCS~~)~~ MMCD Policy Letter 98-10, Breastfeeding Promotion
Other DME Equipment, Breastfeeding: Lactation Management Aids, August 202~~10~~

MONITORING

The Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. This policy will be reviewed for approval by the Alliance's Quality Improvement Health Equity Committee (QIHEC) ~~Healthcare Quality Committee (HCQC) annually~~annually.

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POLICY AND PROCEDURE

Policy Number	UM-054
Policy Name	Notice of Action
Department Name	Health Care Services
Policy Owner	Senior Director Health Care Services
Lines of Business	All
Effective Date	10/12/2017
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

OVERVIEW

Alameda Alliance maintains processes and mechanisms to notify members and providers of Utilization Management (UM) determinations, (medical/surgical and behavioral health,) in a timely manner according to State and Federal regulations as well as NCQA standards.

A. POLICY

1. Members and requesting practitioners are provided with written notifications of UM decisions. These include notice of action (NOA) letters for denials, modifications, and deferrals/delays, which clearly and concisely document and communicate the reasons for the decision so that members and practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

    a. The NOA informs the member of an adverse benefit determination. An adverse benefit determination is defined to mean any of the following actions taken by the Alliance as listed below:

i. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
ii. The reduction, suspension, or termination of a previously authorized service.
iii. The denial, in whole or in part, of payment for a service.
    a) The failure to provide services in a timely manner.
    b) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    c) For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.
    d) The denial of a beneficiary's request to dispute financial liability.

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2. Notification documents
    a. Alameda Alliance utilizes the template NOAs approved by the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).
        i. The Member is informed of Alameda Alliance's decision by a written NOA. The NOA templates are approved by DHCS prior to use. Any changes to the templates are subject to DHCS review and approval prior to use. The NOA includes the "Your Rights under Managed Care" attachment explaining the member's right to the Alliance's appeal process, the State Fair Hearing, and the Independent Medical Review (IMR) process. The member must exhaust their appeal right with the Plan prior to requesting a State Fair Hearing or IMR case.
            1. Deemed exhaustion of appeals processes:
            2. If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing.
            3. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

        ii. Notice of Action (NOA) Requirements
            1. The written NOA shall include the following:
                a) A statement of the action the Alliance intends to take.
                b) A clear and concise explanation of the reasons for the decision. The specific reasons for the denial shall be in easily understandable language and include the clinical reasons for a decision regarding medical necessity.
                c) A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.

d) The clinical reasons for the decision. Alliance shall explicitly state how the member's condition does not meet the criteria or guidelines.
    i. Medical Necessity Denials: Documentation within its system the reason for the denial and the specific evidenced based criterion used to make the denial.
    ii. Benefit Denials: For each benefit/non-medical necessity denial, Document within its system the reason for the denial, including the specific benefit provision, administrative procedure or regulatory limitation used to make the denial.
e) Documentation shall include this information in the denial notice sent to the member or the member's authorized representative.
f) For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.
g) Statement included that the member can request copies of all documents and records relevant to the NOA free of charge, including the criteria and guidelines used. Any requests received by the Plan for the criteria or guidelines will include the specific procedures/conditions that were requested. The following disclosure notice will also be included with all copies of criteria requests "the materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract."
h) The written NOA must have the current DHCS standardized "NOA Your Rights" Template, non-discrimination notice, and language taglines attachments enclosed. The written Your Rights Attachment includes the following:
    i. Member's or provider's right to request an internal Appeal to the Plan within 60 calendar days from the date on the NOA.
    ii. Member's right to request a state hearing only after filing an internal appeal with the Plan and receiving notice that the adverse benefit determination has been upheld.
    iii. Member's right to request a state hearing if the Plan fails to send a resolution notice in response to the

Appeal within the required timeframe (Deemed Exhaustion).

1. Deemed exhaustion of appeals process: If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing

iv. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

v. Procedures for exercising the Member's rights to request an Appeal.

vi. Circumstances under which an expedited review is available and how to request it.

vii. Member's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.

1. The member's rights to Aid Paid Pending and instructions on how to timely file for an appeal (i.e. within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate.

2. Translation
   a) NOA templates must be translated into the required threshold languages.
   b) NOA mailed to the member must be in the preferred threshold language using the translated template. The rationale for the adverse decision will also be translated into the preferred threshold language of the member.
   c) If member's preferred language is non-threshold, the member may request the letter to be translated into their preferred language. AAH will provide the full translation within 21 calendar days.

iii. Member Identifier in Approval and NOA letters:
   1. Member social security numbers or member Medicare HIC numbers can never be used in UM approval or NOA letters. Use of these numbers constitutes a protected health information (PHI) breach.
   2. If there is a legitimate business need to include the member Client Identification Number (CIN) on approval and NOA UM letters, then using the CIN number would be permissible.

iv. NOA Letters to Members and Providers Shall Also Include:
    1. Member Appeal Rights according to the member's product line.
    2. A reference to the evidence-based criteria, benefit provision as described in the member's EOC, guideline, protocol.
    3. Medi-Cal NOA letters shall also include a citation to the specific regulations or Alameda Alliance authorization procedures supporting the action on which the deferral, modification, denial, or termination decision is based.
    4. Information about how the member can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the deferral, modification, denial, or termination decision is based.
    5. Information on accessing interpretive in services in Threshold Languages and information regarding accessing Teletype/Tele Typewriter (TTY) service
    6. Provider right to discuss the UM decision of denial, deferral, modification, or termination with the peer reviewer.
    7. The NOA must include a phone number for the requesting practitioner to call the peer reviewer to discuss the decision.

b. Timeliness of notifications communication
    i. Refer to UM-051 Attachment A for Timeliness Standards for notifications to both provider and member

c. Oversight and monitoring of the notification process
    i. Refer to UM-051

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3. PROCEDURE

a. Production of NOA letters:
    i. Approvals
        1. Automatically generated by the system after approval entered.
        2. NOA approval letters mailed the next business day.
        3. Copy of the letter stored in system.

    ii. Denials
        1. Potential denials forwarded to UM Physician.
        2. Medical review of potential denials completed.
        3. Denial determination made and documented in system.
        4. Forwarded to UM coordinator.
        5. Coordinator produces NOA letter.
        6. NOA mailed the NOA the same day or next business day, and no later than the required two business days for routine authorization decisions, and within 72 hours for urgent authorizations.

b. Reports are generated from data from various sources:
    i. Authorization data systems
    ii. Claims and payments.
    iii. Encounter data
    iv. Medical records

c. The data is compared to available sources of comparable data and benchmarks:
    i. Internally developed performance measures
    ii. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).
    iii. National Medicaid HEDIS results for the 25th and 75th percentiles
    iv. Previous year's network performance
    v. CMS benchmarks when applicable
    vi. NCQA 75th percentile for industry standards
    vii. MCG criteria when applicable

d. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.

e. Out of Network Behavioral Health Data is collected by AAH on at least a quarterly basis
    i. These data are reviewed by the Utilization Management Committee, to monitor the process for appropriate utilization of services.
    ii. Findings are reported at both the Utilization Management and the Quality Improvement Committee meetings because both quality and utilization components are included.
    iii. Detailed analysis may be conducted to determine the root cause of an identified trend.
    iv. Interventions are developed and approved by the Utilization Management and Quality Improvement Committees and carried out by departments.

f. Aggregation of all NOA data including Alameda Alliance, and delegates is done for performance monitoring of NOA compliance

g. Alameda Alliance generates monthly reports to monitor the network performance with the established measures.
    i. A statistical report is generated for outlier practitioners.
        1. A Practitioner Corrective Action Plan is developed as appropriate for outlier providers.
    ii. A statistical report of network adequacy is generated.
        1. A referral to Provider Services is made when network adequacy problems are identified.

h. Data from the monthly analysis is submitted as part of the UM Work Plan to the UM Subcommittee for discussion and recommendations for addressing outlier

results.

i. The UM Subcommittee recommendations are reported to the Quality Improvement Health Equity Committee (QIHEC).

DEFINITIONS

Notice of Action (NOA) is defined as a formal letter from an MCP informing a member of an "adverse benefit determination."

Notice of Appeal Resolution (NAR) is a formal letter from an MCP informing a member of the outcome of an appeal of an adverse benefit determination.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Authorization Processes
UM-051 Timeliness of UM Decisions
CMP-019 Delegation Oversight
BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/15/18, 11/21/19, 1/21/2021, 03/22/2022, 02/21/2023, 6/20/2023, 08/29/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 5 – Utilization Management
DHCS All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights' Attachments—Superseded by APL 21-011
DHCS All Plan Letter 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

MONITORING

The Utilization Management Department, on a routine basis, reviews the results from the authorization audits conducted by the Alliance Compliance Department to ensure compliance with adverse benefit determinations and notice of action requirements.

This policy is reviewed annually to ensure compliance with regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	UM-054
Policy Name	Notice of Action
Department Name	Health Care Services
~~**Department Officer**~~	~~Chief Medical Officer~~
Policy Owner	Senior Director Health Care Services
Lines of Business	All
Effective Date	10/12/2017
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement
Subcommittee Approval Date	TBD~~5/19/2023~~
Compliance Committee Approval Date	TBD~~6/20/2023~~

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OVERVIEW

Alameda Alliance maintains processes and mechanisms to notify members and providers of Utilization Management (UM) determinations, (medical/surgical and behavioral health,) in a timely manner according to State and Federal regulations as well as NCQA standards.

A. POLICY

~~1.0~~

1. Members and requesting practitioners are provided with written notifications of UM decisions. These include notice of action (NOA) letters for denials, modifications, and deferrals/delays, which clearly and concisely document and communicate the reasons for the decision so that members and practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

~~1.1~~

   a. The NOA informs the member of an adverse benefit determination. An adverse benefit determination is defined to mean any of the following actions taken by the Alliance as listed below:

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~~1.1.1~~

i. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

~~1.1.1.1~~ii. The reduction, suspension, or termination of a previously authorized service.

~~1.1.1.2~~iii. The denial, in whole or in part, of payment for a service.

~~1.1.1.3~~a) The failure to provide services in a timely manner.

~~1.1.1.4~~b) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.

~~1.1.1.5~~c) For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.

~~1.1.1.6~~d) The denial of a beneficiary's request to dispute financial liability.

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~~1.2~~2. Notification documents

~~1.2.1~~a. Alameda Alliance utilizes the template NOAs approved by the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

~~1.2.2~~i. The Member is informed of Alameda Alliance's decision by a written NOA. The NOA templates are approved by DHCS prior to use. Any changes to the templates are subject to DHCS review and approval prior to use. The NOA includes the "Your Rights under Managed Care" attachment explaining the member's right to the Alliance's appeal process, the State Fair Hearing, and the Independent Medical Review (IMR) process. The member must exhaust their appeal right with the Plan prior to requesting a State Fair Hearing or IMR case.

~~1.2.2.1~~1. Deemed exhaustion of appeals processes:

~~1.2.2.2~~2. If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing.

~~1.2.2.3~~3. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

~~1.2.3~~ii. Notice of Action (NOA) Requirements

~~1.2.3.1~~1. The written NOA shall include the following:

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~~1.2.3.1.1~~a) A statement of the action the Alliance intends to take.

~~1.2.3.1.2~~b) A clear and concise explanation of the reasons for the decision. The specific reasons for the denial shall be in easily understandable language and include the clinical reasons for a decision regarding medical necessity.

~~1.2.3.1.3~~c) A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.

~~1.2.3.1.4~~d) The clinical reasons for the decision. Alliance shall explicitly state how the member's condition does not meet the criteria or guidelines.

~~1.2.3.1.4.1~~i. Medical Necessity Denials: Documentation within its system the reason for the denial and the specific evidenced based criterion used to make the denial.

~~1.2.3.1.4.2~~ii. Benefit Denials: For each benefit/non-medical necessity denial, Document within its system the reason for the denial, including the specific benefit provision, administrative procedure or regulatory limitation used to make the denial.

~~1.2.3.1.5~~e) Documentation shall include this information in the denial notice sent to the member or the member's authorized representative.

~~1.2.3.1.6~~f) For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.

~~1.2.3.1.7~~g) Statement included that the member can request copies of all documents and records relevant to the NOA free of charge, including the criteria and guidelines used. Any requests received by the Plan for the criteria or guidelines will include the specific procedures/conditions that were requested. The following disclosure notice will also be included with all copies of criteria requests "the materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract."

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~~1.2.3.1.8~~h) The written NOA must have the current DHCS standardized "NOA Your Rights" Template, non-discrimination notice, and language taglines attachments enclosed. The written Your Rights Attachment includes the following:

~~1.2.3.1.8.1~~i. Member's or provider's right to request an internal Appeal to the Plan within 60 calendar days from the date on the NOA.

~~1.2.3.1.8.2~~ii. Member's right to request a state hearing only after filing an internal appeal with the Plan and receiving notice that the adverse benefit determination has been upheld.

~~1.2.3.1.8.3~~iii. Member's right to request a state hearing if the Plan fails to send a resolution notice in response to the Appeal within the required timeframe (Deemed Exhaustion).

~~1.2.3.1.8.3.1~~1. Deemed exhaustion of appeals process: If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing

~~1.2.3.1.8.4~~iv. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

~~1.2.3.1.8.5~~v. Procedures for exercising the Member's rights to request an Appeal.

~~1.2.3.1.8.6~~vi. Circumstances under which an expedited review is available and how to request it.

~~i.~~vii. Member's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.

1. The member's rights to Aid Paid Pending and instructions on how to timely file for an appeal (i.e. within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate.

~~1.2.3.2~~2. Translation

~~1.2.3.2.1~~a) NOA templates must be translated into the required threshold languages.

~~1.2.3.2.2~~b) NOA mailed to the member must be in the preferred threshold language using the translated template. The rationale for the adverse decision will also be

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translated into the preferred threshold language of the member.

~~b)~~c) If member's preferred language is non-threshold, the member may request the letter to be translated into their preferred language. AAH will provide the full translation within 21 calendar days.

~~1.2.4~~iii. Member Identifier in Approval and NOA letters:

~~1.2.4.1~~1. Member social security numbers or member Medicare HIC numbers can never be used in UM approval or NOA letters. Use of these numbers constitutes a protected health information (PHI) breach.

~~1.2.4.2~~2. If there is a legitimate business need to include the member Client Identification Number (CIN) on approval and NOA UM letters, then using the CIN number would be permissible.

~~1.2.5~~iv. NOA Letters to Members and Providers Shall Also Include:

~~1.2.5.1~~1. Member Appeal Rights according to the member's product line.

~~1.2.5.2~~2. A reference to the evidence-based criteria, benefit provision as described in the member's EOC, guideline, protocol.

~~1.2.5.3~~3. Medi-Cal NOA letters shall also include a citation to the specific regulations or Alameda Alliance authorization procedures supporting the action on which the deferral, modification, denial, or termination decision is based.

~~1.2.5.4~~4. Information about how the member can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the deferral, modification, denial, or termination decision is based.

~~1.2.5.5~~5. Information on accessing interpretive in services in Threshold Languages and information regarding accessing Teletype/Tele Typewriter (TTY) service

~~1.2.5.6~~6. Provider right to discuss the UM decision of denial, deferral, modification, or termination with the peer reviewer.

~~1.2.5.7~~7. The NOA must include a phone number for the requesting practitioner to call the peer reviewer to discuss the decision.

~~1.3~~b. Timeliness of notifications communication

~~1.3.1~~i. Refer to UM-051 Attachment A for Timeliness Standards for notifications to both provider and member

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1.4c. Oversight and monitoring of the notification process

1.4.1i. Refer to UM-051

2.03. PROCEDURE

2.1a. Production of NOA letters:

2.1.1i. Approvals

2.1.1.11. Automatically generated by the system after approval entered.

2.1.1.22. NOA approval letters mailed the next business day.

2.1.1.33. Copy of the letter stored in system.

2.1.2ii. Denials

2.1.2.11. Potential denials forwarded to UM Physician.

2.1.2.22. Medical review of potential denials completed.

2.1.2.33. Denial determination made and documented in system.

2.1.2.44. Forwarded to UM coordinator.

2.1.2.55. Coordinator produces NOA letter.

2.1.2.66. NOA mailed the NOA the same day or next business day, and no later than the required two business days for routine authorization decisions, and within 72 hours for urgent authorizations.

2.2b. Reports are generated from data from various sources:

2.2.1i. Authorization data systems

2.2.2ii. Claims and payments.

2.2.3iii. Encounter data

2.2.4iv. Medical records

2.3c. The data is compared to available sources of comparable data and benchmarks:

2.3.1i. Internally developed performance measures

2.3.2ii. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).

2.3.3iii. National Medicaid HEDIS results for the 25th and 75th percentiles

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2.3.4iv. Previous year's network performance
2.3.5v. CMS benchmarks when applicable
2.3.6vi. NCQA 75th percentile for industry standards
2.3.7vii. MCG criteria when applicable

2.4d. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.

2.5e. Out of Network Behavioral Health Data is collected by AAH on at least a quarterly basis
2.5.1i. These data are reviewed by the Utilization Management Committee, to monitor the process for appropriate utilization of services.
2.5.2ii. Findings are reported at both the Utilization Management and the Quality Improvement Committee meetings because both quality and utilization components are included.
2.5.3iii. Detailed analysis may be conducted to determine the root cause of an identified trend.
2.5.4iv. Interventions are developed and approved by the Utilization Management and Quality Improvement Committees and carried out by departments.

2.6f. Aggregation of all NOA data including Alameda Alliance, and delegates is done for performance monitoring of NOA compliance

2.7g. Alameda Alliance generates monthly reports to monitor the network performance with the established measures.

2.7.1i. A statistical report is generated for outlier practitioners.

2.7.1.11. A Practitioner Corrective Action Plan is developed as appropriate for outlier providers.

2.7.2ii. A statistical report of network adequacy is generated.

2.7.2.11. A referral to Provider Services is made when network adequacy problems are identified.

2.8h. Data from the monthly analysis is submitted as part of the UM Work Plan to the UM Subcommittee for discussion and recommendations for addressing outlier results.

2.9i. The UM Subcommittee recommendations are reported to the Quality Improvement Health Equity Committee (QIHEC).

DEFINITIONS

Notice of Action (NOA) is defined as a formal letter from an MCP informing a member of an "adverse benefit determination."~~one~~

Notice of Appeal Resolution (NAR) is a formal letter from an MCP informing a member of the

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outcome of an appeal of an adverse benefit determination.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Authorization Processes
UM-051 Timeliness of UM Decisions
CMP-019 Delegation Oversight
BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/15/18, 11/21/19, 1/21/2021, 03/22/2022, 02/21/2023, 6/20/2023, 08/29/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 5 – Utilization Management
DHCS All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights' Attachments—Superseded by APL 21-011
DHCS All Plan Letter 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

MONITORING

The Utilization Management Department, on a routine basis, reviews the results from the authorization audits conducted by the Alliance Compliance Department to ensure compliance with adverse benefit determinations and notice of action requirements.

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This policy is reviewed annually to ensure compliance with regulatory and contractual requirements.

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Policy Number	UM-055
Policy Name	Palliative Care
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	UM Medical Director
Line(s) of Business	Medi-Cal
Effective Date	1/01/2018
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Pursuant to Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020, and under Alameda Alliance for Health's (Alliance) contract relative to the provision of the Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment [EPSDT]) services, the Alliance authorizes palliative care services to its Medi-Cal members when those services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain, stress and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Section 1915(c) Home and Community Based Services waiver, known as the Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). See APL 13-014, California Children's

Procedure

A. Eligibility Criteria

As outlined in APL 18-020, AAH adopts the DHCS' SB 1004 Palliative Care Policy for the minimum eligibility criteria for palliative care and will authorize palliative care services when medically necessary for members who meet the eligibility criteria.

Members of any age are eligible to receive palliative care services if they meet all the criteria outlined in Section A. below, and at least one of the five requirements outlined in Section B. Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section C below, consistent with the provision of Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT)) services.

B. General Eligibility Criteria:

1. Member must meet all criteria listed in section A, and at least one of the criteria listed in B-E**.**

a. The member is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
b. The member has an advanced illness, as defined in the disease specific eligibility section below, with appropriate documentation of continued decline in health status, and is not eligible for hospice (adult only; ≥ 21 years old) or declines hospice enrollment.
c. The member's death within a year would not be unexpected based on clinical status.
d. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
e. The member and, if applicable, family member/ member-designated support person, agrees to:
    - Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/ palliative care instead of first going to the emergency department; and
    - Participate in Advance Care Planning discussions

C. Disease Specific Eligibility Criteria

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; 10 and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of

predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
   a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone.
   a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
   b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

5. Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:
   a. Profound memory deficits
   b. Functional impairment (ADL dependencies)
   c. Minimal communication
   d. Decreased oral intake and/ or significant weight loss in last six (6) months.
   e. Malnutrition

D. Pediatric Palliative Care Eligibility Criteria

1. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
   a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
   b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
      1. Conditions for which curative treatment is possible, but may fail (e.g., advanced, or progressive cancer or complex and severe congenital or acquired heart disease); or
      2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
      3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
      4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

2. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. AAH has a process to identify members who are eligible for palliative care, including a provider referral process. AAH will periodically assess the member for changes in the member's condition or palliative care needs. AAH may discontinue palliative care that is no longer medically necessary or no longer reasonable.

3. For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and AAH is responsible for the provision of palliative care services related to the CCS-eligible condition. AAH is also responsible for the provision of hospice services for pediatric members.

E. Palliative Care Services

1. When a member meets the minimum eligibility criteria for palliative care, AAH will authorize palliative care without regard to age. Palliative care includes, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

2. Advance Care Planning: Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.

3. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

    - Treatment plans, including palliative care and curative care.
    - Pain, symptoms, and medicine side effects
    - Emotional, stress, and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms.
    - Legally-recognized decision maker

4. Plan of Care: A plan of care is developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care includes all authorized palliative care, including but not limited to pain, and stress and

symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g., CCS Program).

5. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family, and/or legally- recognized decision maker and are able to assist in identifying the member's sources of pain, stress and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members provide all authorized palliative care. DHCS recommends that the palliative care team include but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that there is access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

6. Care Coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs, and implement the plan of care.

7. Pain, Stress and Symptom Management: The member's plan of care includes all services authorized for pain and symptom management. Adequate pain, stress and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain, stress, and other symptoms.

8. Mental Health and Medical Social Services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services does not duplicate specialty mental health services provided by Alameda County Behavioral Health Care Services (ACBHCS). Furthermore, provision of medical and social services does not change AAH's responsibility for referring to, and coordinating with, ACBHCS, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," including any subsequent revisions.

9. AAH has a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. AAH has an adequate network of palliative care providers to meet the needs of members.

10. AAH may, at its discretion and cost, authorize additional palliative care not described above. Examples of additional services offered by some community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/ 7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

F. Providers/ Network

1. Palliative care services may be authorized in the hospital, as part of the inpatient care treatment plan, outpatient (primary care, specialty care clinics), or by community-based settings, such as home health teams, or hospice entities. The Alliance offers a network of palliative care services to its members through various provider types and utilizes qualified providers who comply with the existing Medi-Cal requirements.

2. The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members as long as the provider complies with the existing Medi-Cal requirements.

3. The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

4. The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website, Member Handbook, Member Services, Case Management, and member education materials.

F. Referrals and Authorizations

1. The Alliance identifies members eligible for palliative care by the following:
    - Screening for palliative care eligibility in basic Case Management, Complex Case Management, ECM providers, CBAS designees, Transitions of Care, and 2024 Managed Care Plan Transition for Special Populations.
    - Referrals from network providers, members/ family members/ legal-recognized decision-maker, including through case management. concurrent utilization review, and the general authorization process.
    - Population Health Management: Analysis of member data

G. Authorizations:

1. Palliative care services follow the general authorization process outlined in the Utilization Management (UM) policy and procedure UM-001 and UM-057 Authorizations Process. Authorizations for palliative care services are reviewed as outlined in UM-001 UM Authorizations Process and meet the timeliness standards as outlined in policy and procedure UM-051 Timeliness of UM Decisions.
2. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity.
3. Referral and care coordination for palliative services will be provided to the member within the time or distance access standard requirements.
4. Alliance's network providers receive instructions of the referral and

authorization process for palliative care through the Alliance's provider manual, provider newsletters, educational materials and via the Alliance's website.

H. Grievance and Appeals

1. Member complaints related to the provision of palliative care services and authorization process are processed through the Alliance's Grievance and Appeals system in a manner consistent with grievance and appeals requirements set forth in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments. The process is further described in policy and procedure G&A-001 Grievances and Appeals System Description.

2. The Alliance monitors and collects palliative care enrollment, provider, and utilization data to report to DHCS as specified. The Alliance ensures that their delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS' guidance, including APLs. AAH communicates these requirements to all their delegated entities and subcontractors.

Delegation Oversight

The Alliance adheres to applicable state and federal laws and regulatory requirements, contractual requirements, other DHCS guidance, and accreditation standards for delegates and subcontractors. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

Hospice Care – defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

2024 MCP Transition – Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

Palliative Care – patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Interventions focus primarily on reduction and abatement of pain, stress, and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b).

Special Populations – Members most at risk for harm from disruptions in care or who are least able to access Continuity of Care protections by request or who are identifiable in DHCS data or Previous MCP's data.

Terminally ill – defined in:
1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

Transitions of Care (Population Health Management)– ensures Members are supported from the start of the discharge planning process, through their transition, until they have been successfully connected to all needed services and supports.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Claims
Compliance
Provider Relations and Contracting

RELATED POLICIES AND PROCEDURES

G&A-001 Grievances and Appeals System Description UM-001 Utilization Management
UM-008 Coordination of Care – California Children's Services
UM-011 Coordination of Care – Hospice and Terminal Illness
UM-051 Timeliness of UM Decisions
UM-057 Authorizations

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/04/2018, 3/21/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 09/23/2024

REFERENCES

- CALAIM: Population Health Management (PHM) Policy Guide, May 2024
- California Children's Services, #06-1011
- DHCS APL 13-014 Hospice Services and Medi-Cal Managed Care
- DHCS APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
- DHCS APL 18-020 Palliative Care and Medi-Cal Managed Care
- DHCS APL 21-011 Grievance and Appeal Requirements and Notice and "Your Rights" Templates

- DHCS APL 22-006 Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services
- DHCS Managed Care Policy Letter 11-004.
- DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide, V7
- Medi-Cal Provider Manual "Evaluation and Management (E&M)
- Patient Protection and Affordable Care Act (ACA), Section 2302.
- Senate Bill 1004, Hernandez, Health Care: Palliative Care, Chapter 574, (2014): https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
- Welfare and Institute Code (WIC) Section 14132.75

MONITORING

This policy will be reviewed on an annual basis to ensure it complies with regulatory and contractual requirements.

Policy Number	UM-055
Policy Name	Palliative Care
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	UM Medical Director
Line(s) of Business	Medi-Cal
Effective Date	1/01/2018
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD~~10/11/2023~~
Compliance Committee Approval Date	~~10/19/2023~~ TBD

POLICY STATEMENT

Pursuant to Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020, and under Alameda Alliance for Health's (Alliance) contract relative to the provision of the Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment [~~(~~EPSDT]~~)~~) services, the Alliance authorizes palliative care services to its Medi-Cal members when those services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

~~Note:~~ Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain, ~~and~~ stress and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if ~~the member~~they meet~~s~~ the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Section 1915(c) Home and Community Based Services waiver, known as the Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA)~~. Section 2302, as detailed in~~See APL 13-

014, California Children's Services Numbered Letter 06-1011, and ~~CMS Letter~~Managed Care Policy Letter #1~~1~~0-0~~0418~~.

Procedure

A. Eligibility Criteria

As outlined in APL 18-020, AAH adopts the DHCS' SB 1004 Palliative Care Policy for the minimum eligibility criteria for palliative care and will authorize palliative care services when medically necessary for members who meet the eligibility criteria.

Members of any age are eligible to receive palliative care services if they meet all the criteria outlined in Section A. below, and at least one of the five~~our~~ requirements outlined in Section B. Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section C~~.~~ below, consistent with the provision of Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT)) ~~EPSDT~~ services.

~~•~~B. General Eligibility Criteria:

1. Member must meet all criteria listed in section ~~a~~A, and at least one of the criteria listed in B~~b~~-~~e~~E**e.**
    a. The member is likely to, or has started to, use the hospital or emergency department to ~~as a means to~~to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
    b. The member has an advanced illness, as defined in the disease specific eligibility section below, with appropriate documentation of continued decline in health status, and is not eligible for hospice (adult only; ≥ 21 years old) or declines hospice enrollment.
    c. The member's death within a year would not be unexpected based on clinical status.
    d. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
    e. The member and, if applicable, ~~the~~ family member/ member-designated support person, agrees to:
        - Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/ palliative care instead of first going to the emergency department; and
        - Participate in Advance Care Planning discussions

~~B.~~C. Disease Specific Eligibility Criteria

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; 10 and
    b. The member has an ejection fraction of less than 30 percent for systolic failure

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or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone.
    a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

5. Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:
    a. Profound memory deficits
    b. Functional impairment (ADL dependencies)
    c. Minimal communication
    ~~e.~~ Decreased oral intake and/ or significant weight loss in last six (6) months.
    d.
    ~~d.~~ Malnutrition ~~n).~~
    e.

~~a. Advanced Cancer: Must meet (a) and (b)~~
~~1. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and~~
~~2. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).~~
~~b. Liver Disease: Must meet (a) and (b) combined or (c) alone.~~
~~1. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and~~
~~2. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or~~
~~The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.~~
~~Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:~~
~~Profound memory deficits~~

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~~Functional impairment (ADL dependencies)~~
~~Minimal communication~~
~~Decreased oral intake and/ or significant weight loss in last six (6) months.~~
~~3. Malnutrition).~~

~~•~~D. Pediatric Palliative Care Eligibility Criteria

1. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
   ~~3.~~a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
   ~~4.~~b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
      1. Conditions for which curative treatment is possible, but may fail (e.g., ~~advanced~~advanced, or progressive cancer or complex and severe congenital or acquired heart disease); or
      2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
      3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
      4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

2. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. AAH has a process to identify members who are eligible for palliative care, including a provider referral process. AAH will periodically assess the member for changes in the member's condition or palliative care needs. AAH may discontinue palliative care that is no longer medically necessary or no longer reasonable.

~~C.~~3. For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and AAH is responsible for the provision of palliative care services related to the CCS-eligible condition. AAH is also responsible for the provision of hospice services for pediatric members.

~~D.~~E. Palliative Care Services

1. When a member meets the minimum eligibility criteria for palliative care, AAH will authorize palliative care without regard to age. Palliative care includes, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

2. Advance Care Planning: Advance care planning for members enrolled in ~~MediCal~~Medi-Cal palliative care under SB 1004 includes documented discussions

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between a physician or other qualified healthcare professional and a patient, family member, or legally- recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life- Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.

~~a.~~3. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

- Treatment plans, including palliative care and curative ~~care~~care.
- Pain, symptoms, and medicine side effects
- Emotional, stress, and social challenges
- Spiritual concerns
- Patient goals
- Advance directives, including POLST ~~forms~~forms.
- Legally-recognized decision maker

~~b.~~4. Plan of Care: A plan of care is developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care includes all authorized palliative care, including but not limited to pain, and stress and symptom management ~~pain and symptom management~~ and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g., CCS Program).

~~2.~~5. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family, and/or legally- recognized decision maker and are able to assist in identifying the member's sources of pain, stress and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members provide all authorized palliative care. DHCS recommends that the palliative care team include but is not limited to the following team members: a d~~D~~octor of m~~M~~edicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. ~~(~~DHCS also recommends that there is access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.~~)~~

~~a.~~6. Care Coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs, and implement the plan of care.

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~~b.~~7. Pain, Stress, and Symptom Management: The member's plan of care includes all services authorized for pain and symptom management. Adequate pain, stress and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain, stress, and other symptoms.

8. Mental Health and Medical Social Services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services does not duplicate specialty mental health services provided by Alameda County Behavioral Health Care Services~~,~~ (ACBHCS). Furthermore, provision of medical and social services does not change AAH's responsibility for referring to, and coordinating with, ACBHCS, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," ~~(~~including any subsequent revisions.~~)~~

~~3.~~9. AAH has a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. AAH has an adequate network of palliative care providers to meet the needs of members.

~~4.~~10. AAH may, at its discretion and cost, authorize additional palliative care not described above. Examples of additional services offered by some community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/ 7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

F. Providers/ Network

1. Palliative care services may be authorized in~~delivered at~~ the hospital, as part of the inpatient care treatment plan, ~~or authorized and delivered in~~outpatient (~~-~~primary care, specialty care clinics), or by community-based settings, such as ~~by~~ home health teams, or ~~by~~ hospice entities. The Alliance offers a network of palliative care services to its members through various provider ~~types~~types and utilizes qualified providers who comply with the existing Medi-Cal requirements.~~.~~

2. The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or

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training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members as long as the provider complies with the existing Medi-Cal requirements.

3. The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

4. The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website, Member Handbook, Member Services, Case Management, and member education materials.

~~E.~~F. Referrals and Authorizations

1. The Alliance identifies members eligible for palliative care by the following:
   - Screening for palliative care eligibility in basic Case Management, Complex Case Management, ECM providers, CBAS designees, Transitions of Care, and 2024 Managed Care Plan Transition for Special Populations. ~~referrals~~
   - Referrals from network providers, members/ family members/ legal-recognized decision-maker, including through case management, ~~,~~ concurrent utilization review, and the general authorization process.
   - Population Health Management: Analysis of member data

~~F.~~G. Authorizations:

1. Palliative care services follow the general authorization process outlined in the Utilization Management (UM) policy and procedure UM-001 and UM-057 Authorizations Process. Authorizations for palliative care services are reviewed as outlined in UM-001 UM Authorizations Process and meet the timeliness standards as outlined in policy and procedure UM-051 Timeliness of UM Decisions.
2. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity.
3. Referral and care coordination for palliative services will be provided to the member within the time or distance access standard requirements.
4. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider manual, provider newsletters, educational materials and via the Alliance's website.

~~G.~~H. Grievance and Appeals

1. Member complaints related to the provision of palliative care services and authorization process are processed through the Alliance's Grievance and Appeals system in a manner consistent with grievance and appeals requirements set forth in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments. The process is further described in policy and procedure G&A-001 Grievances and Appeals System Description.

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2. The Alliance monitors and collects palliative care enrollment, provider, and utilization data to report to DHCS as specified. The Alliance ensures that their delegates comply with all

2. applicable state and federal law and regulations and other contractual requirements as well as DHCS' guidance, including APLs. AAH communicates these requirements to all their delegated entities and subcontractors.

Delegation Oversight

The Alliance adheres to applicable state and federal laws and regulatory requirements, contractual requirements, other DHCS guidance, and accreditation standards for delegates and subcontractors. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

Hospice Care – defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

2024 MCP Transition – Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

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Special Populations – Members most at risk for harm from disruptions in care or who are least able to access Continuity of Care protections by request or who are identifiable in DHCS data or Previous MCP's data.

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1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
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Transitions of Care (Population Health Management)– ensures Members are supported from the start of the discharge planning process, through their transition, until they have been successfully connected to all needed services and supports.

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Claims
Compliance
Provider Relations and Contracting

RELATED POLICIES AND PROCEDURES

G&A-001 Grievances and Appeals System Description UM-001 Utilization Management
UM-008 Coordination of Care – California Children's Services
UM-011 Coordination of Care – Hospice and Terminal Illness
UM-051 Timeliness of UM Decisions
UM-057 Authorizations

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/04/2018, 3/21/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 09/23/2024

REFERENCES

- CALAIM: Population Health Management (PHM) Policy ~~G~~Guide, May 2024
- California Children's Services, #06-1011
- DHCS APL 13-014 Hospice Services and Medi-Cal Managed Care
- DHCS APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
- DHCS APL 18-020 Palliative Care and Medi-Cal Managed Care ~~SB 1004 Hernandez, Chapter 574, Statutes of 2014~~
- DHCS APL 21-011 Grievance and Appeal Requirements and Notice and "Your Rights" Templates
- DHCS APL 22-006 Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services
- ~~DHCS website: http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx~~DHCS Managed Care Policy Letter 11-004.
- DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide, V7
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MONITORING

This policy will be reviewed on an annual basis to ensure it complies with regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

OVERVIEW

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity.

B. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary

to obtain such authorizations.

1. Communication shall include the data and information the Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) that guide the UM decision-making process.
2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
    i. alamedaalliance.org/providers/provider-resources
    ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as PA timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Criteria (EOC). If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service.If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, The Alliance will do the following:

    1. Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
    2. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
    3. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
    4. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

D. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria,disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations for Group Care members are based on non-profit professional

organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH).

E. The below services are exempt from prior authorization, based on regulatory requirements:
    1. Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
    2. Urgent care, whether in or out of network
    3. Primary Care Visits
    4. Preventative Services
    5. Immunizations/Vaccines
    6. Annual Cognitive Assessment for Medi-Cal members over 65 without MediCare.
    7. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
    8. Basic perinatal care – a woman can go directly to any network provider for basic perinatal care.
    9. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
    10. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
    11. HIV testing and counseling.
    12. Minors do not need authorization for:
        a. Sexual or physical abuse
        b. Suicidal ideations
        c. Pregnancy care
        d. Sexual assault
        e. Drug and alcohol abuse treatment
    13. Biomarker testing which is FDA approved
        a. For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 (**Health & Safety Code §1367.665**).

F. The below services provided by the Alliance's direct network do not require prior authorization:
    1. Specialty visits (initial and follow-up visits)
    2. Mental Health and Substance Use Disorder outpatient visits
    3. Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

G. The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:
    1. Regulatory/Contractual guidelines
    2. Member access to services

3. Utilization patterns:
    a. Volume of authorizations
    b. Volume of authorizations approved, denied, modified or deferred after medical necessity reviews
4. Patient safety
5. Provider consistency in scope of utilization requests

H. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:
    1. Regulatory/Contractual guidelines
    2. Member access to services
    3. Utilization patterns:
        a. Volume of authorizations
        b. Volume of authorizations approved, denied, modified or deferred after medical necessity reviews
    4. Patient safety
    5. Provider consistency in scope of utilization requests

    The list of services on auto-authorization is reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization guidelines after approval by UMC and QIHEC (see attachment section of the policy).

I. Services for which authorization is required include, but are not limited to:

    1. Out-of-network providers/ services/ facilities.
    2. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
    3. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT)
    4. Selected major diagnostic tests.
    5. Home Health Care/ Private Duty Nursing care.
    6. Selected durable medical equipment.
    7. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
    8. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
    9. CBAS services.
    10. Inpatient admissions (non-emergency).
    11. Inpatient hospice care.
    12. Inpatient abortions.
    13. Skilled nursing facilities admissions.
    14. Long-term care (LTC) Custodial Nursing Facility admissions.
    15. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions

16. Subacute Admissions
17. LTC Skilled nursing facilities Bed Hold/ Leave of Absence
18. Major Organ Transplant Services
19. Out of Network Second opinion
20. Podiatry services
21. Acupuncture, greater than 4 visits per month for Adult. Limits do not apply for children under the age of 21.
22. Chiropractic
23. Treatment and services related to gender dysphoria

J. Immunization/Vaccination
    1. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, The Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.

K. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.
    1. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
        a. Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the AAH coding list will be updated at least annually. Any updates are configured in the AAH UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.
    2. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:
        a. A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
        b. A national coverage determination made by the Centers for Medicare and Medicaid Services
        c. A local coverage determination made by a Medicare Administrative Contractor for California

d. Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff
e. Standards set by the National Academy of Medicine

Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.

L. Non-Benefit Codes
1. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.
    a. Exceptions never covered are Infertility Preservation services for Medi Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
    b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
    c. All potential denials of these services will go to the MD for review and final determination

M. Unlisted Codes
1. The Alliance may cover a unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.
    a. Exceptions never covered are Infertility Preservation services for Medi Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
    b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
    c. All potential denials of these services will go to the MD for review and final determination

N. Standard Fertility Services

1. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

2. For Medi-Cal members the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos are not covered.

O. Indian Health Service Programs

1. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

P. Appropriate Classification of Determination
   1. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
   2. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
   3. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

Q. The Alliance service types are processed as:
   1. Prior Authorization
   2. Concurrent, inpatient
   3. Concurrent, Outpatient (care currently underway)
   4. Post-Service/Retrospective Review

R. The Alliance authorization determinations are documented as:
   1. Approved
   2. Modified
   3. Denied
   4. Delayed

S. UM Decision Making
   1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
      a. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
      b. Decisions to deny or to authorize an amount, duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
      c. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
      d. UM Reviewers make UM authorization approval decisions based on UM

Committee approved auto authorization criteria and other UM Committee approved UM criteria UM-001, and auto authorization criteria.

i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002

e. Qualified doctoral Behavioral Health (BH) Reviewer staff make BH authorization approval decisions based on QIHEC approved BH UM criteria.
   i. See UM-012 Care Coordination policy regarding approved BH UM criteria.
f. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
g. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.
h. Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility.
i. Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002

T. In instances where The Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The Alliance shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as The Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if The Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.

U. The Alliance shall make all UM decisions and notifications within the required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, The Alliance shall adhere to the strictest standard.

V. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:
   1. Determining and ensuring response appropriate to urgency of request.
   2. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
   3. Ensuring that correct UM criteria are selected for review of request.
   4. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
   5. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

W. When determining medical necessity, The Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination

is not available, The Alliance works with the requesting providers to obtain the information in a timely manner.

X. Rescission
    1. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when The Alliance did not make an accurate determination of the member's eligibility.

Y. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

Z. Authorization of Enhanced Care Management (ECM)
    1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:
        a. Routine requests not to exceed 5 days.
        b. Expedited requests not to exceed 72 hours.
    2. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:
        a. Provider notification not to exceed 24 hours, (oral or written) after decision.
        b. Written notification to provider and member not to exceed 2 working days after decision.
    3. The Alliance will authorize ECM for a minimum of 6 months for each request.
        a. Delegated ECM Providers and/ or their subcontractors must follow The Alliance authorization requirements, including adjudication standards and referral documentation.
    4. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
    5. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
    6. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

Y. Authorization of Community Supports (CS) Services
    1. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
        a. Routine requests not to exceed 5 business days.
    2. Expedited requests not to exceed 72 hours.2. Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:
        a. Provider notification not to exceed 24 hours, (oral or written) after decision.
        b. Written notification to provider and member not to exceed 2 working days after decision.

AA. Post Service/Retrospective Review Process

The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past

the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

1. Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.
2. In-patient services where the facility is unable to confirm enrollment with the Alliance.

BB. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients will transition from a previous MCP to Alameda Alliance for Health (The Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members transitioning into The Alliance will adhere to the requirements of the 2024 Managed Care Plan Transition Policy Guide and All Plan Letter (APL) 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

1. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.
2. Particular attention and resources will be focused on members in Special Populations:
    a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services
    b. Adults and children with authorizations to receive Community Supports (CS).
    c. Adults and children receiving Complex Care Management (CCM)
    d. Enrolled in 1915(c) waiver programs
    e. Receiving in-home supportive services (IHSS)
    f. Children and youth enrolled in California Children's Services (CCS)
    g. Children and youth receiving foster care, and former foster youth through age 25
    h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
    i. Taking immunosuppressive medications, immunomodulators, and biologics
    j. Receiving treatment for end-stage renal disease (ESRD)
    k. Living with an intellectual or developmental disability (I/DD) diagnosis
    l. Living with a dementia diagnosis
    m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
    n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
    o. Receiving specialty mental health services (adults, youth, and children)
    p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal

symptoms or mortality
q. Receiving hospice care
r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care
v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

CC. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

1. Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on The Alliance website and are available upon request.
2. Non-contracted providers are informed via The Alliance website/Section – Authorization.

PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax, in writing, or via secure portal.
2. Upon receipt of the authorization request, the UM Authorization Coordinator (AC) will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      ii. Presence of medical records.

3. Once the authorization request review is complete, the AC enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned AC reviews the pre-service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the AC approves the request following UM guidelines via Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the AC routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse / BH Reviewer/ or Pharmacy technician performs a medical necessity review

of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.

a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:
c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.
d) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) When making a determination of coverage based on medical necessity relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   d) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
      i. Office and hospital records
      ii. A history of the present problem
      iii. A clinical exam
      iv. Diagnostic testing results
      v. Treatment plans and progress notes
      vi. Patient psychosocial history
      vii. Information on consultations with the treating practitioner
      viii. Evaluations from the other health care practitioners and providers
      ix. Photographs
      x. Operative and pathological reports
      xi. Rehabilitation evaluations
      xii. A printed copy of criteria related to the request.
      xiii. Information regarding benefits for services of procedures
      xiv. Information regarding the local delivery system
      xv. Patient characteristics and information
      xvi. Information from responsible family members
      xvii. Minimum Data Set (MDS)

xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

B. Missing Clinical Information:
1. Formal requests for missing information can be made either by phone or in writing.
   a) Missing information includes:
      i. Incomplete name, ID number, contact information.
      ii. Diagnosis or Service codes
      iii. Incomplete Attachments
      iv. Required Title XXII forms
2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician/ Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three attempts will be made:
      i. 1 Fax and 2 phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician/doctoral BH/ Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the UM Physician/ Medical Director BH Reviewer/ or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
3. Formal requests for additional information must be made in writing to the provider and the member using the most recent DHCS or The Alliance templates.
4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.
5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
6. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director/ BH Reviewer/ or Pharmacist may approve the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.
   a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director/Physician Reviewer Review
   1. The Medical Director/Physician /doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director/Physician Reviewer /doctoral BH reviews the information summary provided by the UM Nurse /BH Reviewer, the clinical information, and the appropriate UM Criteria.
      a) The Medical Director/Physician doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
      b) To evidence appropriate professional review, each UM case must include one of the following:
         i. The reviewer's written signature or initials
         ii. The reviewer's unique electronic signature or identifier on the denial notation
         iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

   2. Once the Medical Director/Physician doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse/ Coordinator /BH Reviewer/ or Pharmacy technician for processing:
      a) Approvals: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.
      b) Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions
   1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with The Alliance decision maker. Providers are notified of this process in the UM determination notifications.
      a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with The Alliance UM decision maker.
      b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the Notice of Action Letter.
         i. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director/ Behavioral Health/ Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit
   2. The Alliance easy access for Providers and utilizes The Alliance UM telephone number to serve as the entry point of contact.
   3. UM / BH Staff/ Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:
      a) Member name and ID#
      b) Referral #
      c) Name of the Physician requesting the return call.

d) Contact number for the requesting Physician.
e) Best time to reach the requesting Physician.

4. UM / BH/ or Pharmacy Staff will note the request for the discussion in the TrueCare Case and notify the appropriate UM decision maker.
   a) If The Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.
5. Every attempt is made to return calls on the same day.
   a) Two attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
   b) The Alliance Physician/ Medical Director / doctoral BH Reviewer/ Pharmacist will document all outreach attempts in TrueCare.
6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
   - In the denial notification, ***or***
   - By telephone, ***or***
   - In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
7. The organization includes the following information in the denial file:
   - The denial notification, if the treating practitioner was notified in the denial notification.
   - The time and date of the notification, if the treating practitioner was notified by telephone.
   - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician/ Medical Director/ / doctoral BH Reviewer/ Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician/ Medical Director / doctoral BH Reviewer/ or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.
   1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician/ Medical Director/ / doctoral BH Reviewer/ or Pharmacist will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers
   1. The Alliance requires services to be provided within the contracted network.
      a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which The Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

   2. When services are not available within the network:
      a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason

for the request.

b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes case.

c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer/ or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.

d) The UM Nurse / BH Reviewer/ Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.

   i. If determined services are medically necessary but not available within The Alliance network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer/ or Pharmacist reviews with the Physician/ Medical Director/ doctoral BH Reviewer/ or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time letter of agreement through Provider Network Operations.

   ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews case with the Physician/ Medical Director/ /doctoral BH Reviewer/ or Pharmacist to possible re- direct into the network.

      (i) If determination is to re-direct, the UM Nurse / BH Reviewer/ Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.

      (ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH/ Pharmacy Department using medical necessity review criteria.

   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist and changed to a routine urgency status.

2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.

   a) UM Coordinator will review post-service request to ensure:

      i. Member was eligible at the time of services.

      ii. Services required prior authorization.

      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.

b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
c) If documentation found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer/ or Pharmacist to confirm the services authorized match the services requested.
    i. UM Nurse / BH Reviewer/ or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.
        (i) If the services match, the case will be completed as approved and closed according to policy.

3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted greater than 90 calendar days from the date of service.
    a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.
4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater than 90 calendar days from the date of service:
    a) Services will be denied as "no authorization obtained for service that required prior authorization."
        i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.
    b) UM Coordinator will route request to the Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
    c) The Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.
        i. If documentation supports prior authorization was required and not obtained, Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings and deny case as "no prior authorization obtained."
        ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings for approval along with the reasons.
    d) Case is routed back to the UM Coordinator to complete the member and provider notifications.
    e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)
1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH/ Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance QI Policy Potential Quality of Care Issues.

J. Referrals to Care Management
1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network

Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service's needs, then the UM staff will complete the Care Management / CCS/ BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management /BH Policies.

K. Reporting and Tracking

1. All pre-service requests are entered into The Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
2. HealthCare Analytics has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.
3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services

1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
   a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
   b) UM Staff will process referral request as defined in Sections 3.1
   c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH/ Pharmacy departments provides oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations** – pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

Behavioral Healthcare Practitioner (BHP) is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical arear of practice.

C. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

D. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

E. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

F. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

G. **Doctoral Behavioral Health Reviewer** is a licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

H. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

I. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

J. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

K. **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

L. **Medical Necessity Determination** means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

M. **Member** means any eligible beneficiary who has enrolled in the The Alliance and who has been assigned to or selected a Plan.

N. **National Committee for Quality Assurance (NCQA**) is a non-profit organization committed

to evaluating and public reporting on the quality of health plans and other health care entities.

O. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with The Alliance.

P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

R. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

   i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

S. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

T. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

U. **UM /BH Reviewer** is a Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. They apply QIHEC approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance Website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care

7. CM-009 ECM Program Infrastructure
8. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
9. RX-002 PA Review Process
10. UM - 054 Policy Notice of Action
11. UM -059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, , 7/17/2024, 10/25/2024

REFERENCES

- SB 600, Section 1374.551. (a)
- "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- DHCS Provider Manual, Family Planning, June 2022, page 1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
- Title 22, Section 51159
- 28 CCR, §1300.51 (d)(I-6)
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- NCQA Standards, Utilization Management
- WIC Section 14197
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.

Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability. The Alliance also ensure interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional detail about the Inter-Rater Reliability Process.

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	TBD~~7/17/2024~~

OVERVIEW

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

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The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

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POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity.

B. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary

to obtain such authorizations.

~~a.~~1. ~~The communication~~Communication shall include the data and information ~~t~~The Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) ~~and~~ that guide the UM decision-making process.

~~b.~~2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:

~~o~~i. alamedaalliance.org/providers/provider-resources

~~o~~ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/

~~c.~~3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as PA timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Criteria (EOC). If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service~~., and i~~If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, The Alliance will do the following:

~~C.~~

1. ~~(1)~~ Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
2. ~~(2)~~ Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
3. ~~(3)~~ Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
4. ~~(4)~~ Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

D. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria~~, and~~ disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations for Group Care members are based on non-profit

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professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH).

E. The below services are exempt from prior authorization, based on regulatory requirements:
   - ~~a.~~1. Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
   - ~~b.~~2. Urgent care, whether in or out of network
   - ~~c.~~3. Primary Care Visits
   - ~~d.~~4. Preventative Services
   - ~~e.~~5. Immunizations/Vaccines
   - ~~f.~~6. Annual Cognitive Assessment for Medi-Cal members over 65 without MediCare.
   - ~~g.~~7. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
   - ~~h.~~8. Basic perinatal care – a woman can go directly to any network provider for basic perinatal care.
   - ~~i.~~9. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
   - ~~j.~~10. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
   - ~~k.~~11. HIV testing and counseling.
   - ~~l.~~12. Minors do not need authorization for:
     - ~~a~~a. Sexual or physical abuse
     - ~~b~~b. Suicidal ideations
     - ~~c~~c. Pregnancy care
     - ~~d~~d. Sexual assault
     - ~~e~~e. Drug and alcohol abuse treatment
   - ~~m.~~13. Biomarker testing which is FDA approved
     - ~~a~~a. For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 (**Health & Safety Code §1367.665**).

F. The below services provided by the Alliance's direct network do not require prior authorization:
   - ~~a.~~1. Specialty visits (initial and follow-up visits)
   - ~~b.~~2. Mental Health and Substance Use Disorder outpatient visits
   - ~~c.~~3. Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

G. The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:
   - 1. Regulatory/Contractual guidelines
   - 2. Member access to services

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- 3. Utilization patterns:
  - ~~a.~~ Volume of authorizations
  - ~~b.~~ Volume of authorizations approved, denied, modified or deferred after medical necessity reviews
- 4. Patient safety
- 5. Provider consistency in scope of utilization requests

~~The list of services/codes that do and do not require prior authorization is reviewed and approved at least annually at UMC and QIHEC.~~

~~G.~~H. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:

~~a.~~1. Regulatory/Contractual guidelines
~~b.~~2. Member access to services
~~c.~~3. Utilization patterns:
  - ~~a.~~ Volume of authorizations
  - ~~b.~~ Volume of authorizations approved, denied, modified or deferred after medical necessity reviews

~~d.~~4. Patient safety
~~e.~~5. Provider consistency in scope of utilization requests

The list of services on auto-authorization is reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization guidelines after approval by UMC and QIHEC (see attachment section of the policy).

~~H.~~I. Services for which authorization is required include, but are not limited to:

~~a.~~1. Out-of-network providers/ services/ facilities.
~~b.~~2. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
~~c.~~3. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT)
~~d.~~4. Selected major diagnostic tests.
~~e.~~5. Home Health Care/ Private Duty Nursing care.
~~f.~~6. Selected durable medical equipment.
~~g.~~7. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
~~h.~~8. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
~~i.~~9. CBAS services.
~~j.~~10. Inpatient admissions (non-emergency).
~~k.~~11. Inpatient hospice care.
~~l.~~12. Inpatient abortions.

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~~m.~~13. Skilled nursing facilities admissions.
14. Long-term care (LTC) Custodial Nursing Facility admissions.
15. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions
~~n.~~16. Subacute Admissions
~~o.~~17. LTC Skilled nursing facilities Bed Hold/ Leave of Absence
~~p.~~18. Major Organ Transplant Services
~~q.~~19. Out of Network Second opinion
~~r.~~20. Podiatry services
~~s.~~21. Acupuncture, greater than 4 visits per month for Adult. Limits do not apply for children under the age of 21.
~~t.~~22. Chiropractic
~~u.~~23. Treatment and services related to gender dysphoria

~~I.~~J. Immunization/Vaccination

~~a.~~1. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, The Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.

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~~J.~~K. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.

~~a.~~1. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.

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~~o~~a. Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the AAH coding list will be updated at least annually. Any updates are configured in the AAH UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.

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~~b.~~2. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:

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~~o~~a. A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug

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~~o~~b. A national coverage determination made by the Centers for Medicare and

Medicaid Services

~~c.~~ A local coverage determination made by a Medicare Administrative Contractor for California

~~d.~~ Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff

~~e.~~ Standards set by the National Academy of Medicine

Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.

~~K.~~L. Non-Benefit Codes

1. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.
   a. Exceptions never covered are Infertility Preservation services for Medi Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
   b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
   c. All potential denials of these services will go to the MD for review and final determination

M. Unlisted Codes

1. The Alliance may cover a unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.
   a. Exceptions never covered are Infertility Preservation services for Medi Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
   b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
   c. All potential denials of these services will go to the MD for review and final determination

~~L.~~N. Standard Fertility Services

~~a.~~1. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

~~b.~~2. For Medi-Cal members the following fertility preservation services, including but not

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limited to cryopreservation of sperm, oocytes, or fertilized embryos are not covered.

M.O. Indian Health Service Programs

a.1. The Alliance will ensure qualified Members have timely access to Indian Health Service IHS (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

N.P. Appropriate Classification of Determination

a.1. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.

b.2. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.

c.3. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

O.Q. The Alliance service types are processed as:

a.1. Prior Authorization

b.2. Concurrent, inpatient

c.3. Concurrent, Outpatient (care currently underway)

d.4. Post-Service/Retrospective Review

P.R. The Alliance authorization determinations are documented as:

a.1. Approved

b.2. Modified

c.3. Denied

d.4. Delayed

Q.S. UM Decision Making

a.1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:

oa. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.

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- ~~o~~ Decisions to deny or to authorize an amount, duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. Appropriate clinical expertise
- b. may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
- ~~o~~c. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
- ~~o~~d. UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria and other UM Committee approved UM criteria UM-001, and auto authorization criteria.
  - i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002
- ~~o~~e. Qualified doctoral Behavioral Health (BH) Reviewer staff make BH authorization approval decisions based on QIHEC approved BH UM criteria.
  - i. See UM-012 Care Coordination policy regarding approved BH UM criteria.
- ~~o~~f. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
- ~~o~~g. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.
- ~~o~~h. Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility.
- i. Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002
- ~~o~~

~~R.~~T. In instances where The Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The Alliance shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as The Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if The Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the ~~beneficiary's best interest~~best interests of the beneficiary.

~~S.~~U. The Alliance shall make all UM decisions and notifications within ~~required~~the required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, The Alliance shall adhere to the strictest standard.

~~T.~~V. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:

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~~a.~~1. Determining and ensuring response appropriate to urgency of request.
~~b.~~2. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
~~c.~~3. Ensuring that correct UM criteria are selected for review of request.
~~d.~~4. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
~~e.~~5. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

~~U.~~W. When determining medical necessity, The Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, The Alliance works with the requesting providers to obtain the information in a timely manner.

~~V.~~X. Rescission

~~a.~~1. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when The Alliance did not make an accurate determination of the member's eligibility.

~~W.~~Y. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

~~X.~~Z. Authorization of Enhanced Care Management (ECM)

1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:
   a. Routine requests not to exceed 5 days.
   b. Expedited requests not to exceed 72 hours.
2. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:
   a. Provider notification not to exceed 24 hours, (oral or written) after decision.
   b. Written notification to provider and member not to exceed 2 working days after decision.
3. The Alliance will authorize ECM for a minimum of 6 months for each request.
   a. Delegated ECM Providers and/ or their subcontractors must follow The Alliance authorization requirements, including adjudication standards and referral documentation.
4. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
5. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
6. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

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~~Y.~~ Y. Authorization of Community Supports (CS) Services

~~a.~~ 1. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:

~~o~~ a. Routine requests not to exceed 5 business days.

~~o~~ Expedited requests not to exceed 72 hours.

~~b.~~2. 2. Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:

~~o~~ a. Provider notification not to exceed 24 hours, (oral or written) after decision.

~~o~~ b. Written notification to provider and member not to exceed 2 working days after decision.

~~Z.~~AA. Post Service/Retrospective Review Process

The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

~~a.~~1. Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.

~~b.~~2. In-patient services where the facility is unable to confirm enrollment with the Alliance.

~~AA.~~BB. On January 1, 2024, Alameda County ~~will~~ transitioned to a Single Plan Model county, and Medi-Cal recipients will transition from a previous MCP to Alameda Alliance for Health (The Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members transitioning into The Alliance will adhere to the requirements of the 2024 Managed Care Plan Transition Policy Guide and All Plan Letter (APL) 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

~~o~~1. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

~~o~~2. Particular attention and resources will be focused on members in Special Populations:

- a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services
- b. Adults and children with authorizations to receive Community Supports (CS).
- c. Adults and children receiving Complex Care Management (CCM)
- d. Enrolled in 1915(c) waiver programs
- e. Receiving in-home supportive services (IHSS)

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- f. Children and youth enrolled in California Children's Services (CCS)
- g. Children and youth receiving foster care, and former foster youth through age 25
- h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- i. Taking immunosuppressive medications, immunomodulators, and biologics
- j. Receiving treatment for end-stage renal disease (ESRD)
- k. Living with an intellectual or developmental disability (I/DD) diagnosis
- l. Living with a dementia diagnosis
- m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- o. Receiving specialty mental health services (adults, youth, and children)
- p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- q. Receiving hospice care
- r. Receiving home health
- s. Residing in Skilled Nursing Facilities (SNF)
- t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- u. Receiving hospital inpatient care
- v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- w. Newly prescribed DME (within 30 days of January 1, 2024)
- x. Members receiving Community-Based Adult Services (CBAS)

o 3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

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~~BB.~~CC. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

- 1. Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on The Alliance website and are available upon request.
- 2. Non-contracted providers are informed via The Alliance website/Section – Authorization.

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PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax, in writing, or via secure portal.
2. Upon receipt of the authorization request, the UM Authorization Coordinator (AC) will review the request for:

a) Member eligibility
b) Completeness of the request
   i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
   ii. Presence of medical records.

3. Once the authorization request review is complete, the AC enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned AC reviews the pre-service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the AC approves the request following UM guidelines via Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the AC routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse / BH Reviewer/ or Pharmacy technician performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.

   a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
   b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:
   c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.
   d) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) When making a determination of coverage based on medical necessity relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   d) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited

to, the following:

i. Office and hospital records
ii. A history of the present problem
iii. A clinical exam
iv. Diagnostic testing results
v. Treatment plans and progress notes
vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members
xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

B. Missing Clinical Information:
1. Formal requests for missing information can be made either by phone or in writing.
   a) Missing information includes:
      i. Incomplete name, ID number, contact information.
      ii. Diagnosis or Service codes
      iii. Incomplete Attachments
      iv. Required Title XXII forms
2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician/ Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three attempts will be made:
      i. 1 Fax and 2 phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician/doctoral BH/ Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the UM Physician/ Medical Director BH Reviewer/ or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) “delay” template to the provider

and beneficiary within the required timeframe.

3. Formal requests for additional information must be made in writing to the provider and the member using the most recent DHCS or The Alliance templates.
4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.
5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
6. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director/ BH Reviewer/ or Pharmacist may approve the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.
   a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director/Physician Reviewer Review
   1. The Medical Director/Physician /doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director/Physician Reviewer /doctoral BH reviews the information summary provided by the UM Nurse /BH Reviewer, the clinical information, and the appropriate UM Criteria.
      a) The Medical Director/Physician doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
      b) To evidence appropriate professional review, each UM case must include one of the following:
         i. The reviewer's written signature or initials
         ii. The reviewer's unique electronic signature or identifier on the denial notation
         iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

   2. Once the Medical Director/Physician doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse/ Coordinator /BH Reviewer/ or Pharmacy technician for processing:
      a) Approvals: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.
      b) Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions
   1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with The Alliance decision maker. Providers are notified of

this process in the UM determination notifications.

a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with The Alliance UM decision maker.
b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the Notice of Action Letter.
    i. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director/ Behavioral Health/ Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit

2. The Alliance easy access for Providers and utilizes The Alliance UM telephone number to serve as the entry point of contact.
3. UM / BH Staff/ Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:
    a) Member name and ID#
    b) Referral #
    c) Name of the Physician requesting the return call.
    d) Contact number for the requesting Physician.
    e) Best time to reach the requesting Physician.
4. UM / BH/ or Pharmacy Staff will note the request for the discussion in the TrueCare Case and notify the appropriate UM decision maker.
    a) If The Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.
5. Every attempt is made to return calls on the same day.
    a) Two attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
    b) The Alliance Physician/ Medical Director / doctoral BH Reviewer/ Pharmacist will document all outreach attempts in TrueCare.
6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
    - In the denial notification, ***or***
    - By telephone, ***or***
    - In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
7. The organization includes the following information in the denial file:
    - The denial notification, if the treating practitioner was notified in the denial notification.
    - The time and date of the notification, if the treating practitioner was notified by telephone.
    - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician/ Medical Director/ / doctoral BH Reviewer/ Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician/ Medical Director / doctoral BH Reviewer/ or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity

determination.

1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician/ Medical Director/ / doctoral BH Reviewer/ or Pharmacist will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers

1. The Alliance requires services to be provided within the contracted network.
   a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which The Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

2. When services are not available within the network:
   a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason for the request.
   b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes case.
   c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer/ or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.
   d) The UM Nurse / BH Reviewer/ Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
      i. If determined services are medically necessary but not available within The Alliance network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer/ or Pharmacist reviews with the Physician/ Medical Director/ doctoral BH Reviewer/ or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time letter of agreement through Provider Network Operations.
      ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews case with the Physician/ Medical Director/ /doctoral BH Reviewer/ or Pharmacist to possible re- direct into the network.
         (i) If determination is to re-direct, the UM Nurse / BH Reviewer/ Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.
         (ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

   e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH/ Pharmacy Department using medical necessity review criteria.
   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist and changed to a routine urgency status.
2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.
   a) UM Coordinator will review post-service request to ensure:
      i. Member was eligible at the time of services.
      ii. Services required prior authorization.
      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.
   b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
   c) If documentation found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer/ or Pharmacist to confirm the services authorized match the services requested.
      i. UM Nurse / BH Reviewer/ or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.
         (i) If the services match, the case will be completed as approved and closed according to policy.
3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted greater than 90 calendar days from the date of service.
   a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.
4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater than 90 calendar days from the date of service:
   a) Services will be denied as "no authorization obtained for service that required prior authorization."
      i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.
   b) UM Coordinator will route request to the Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
   c) The Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.
      i. If documentation supports prior authorization was required and not obtained, Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings and deny case as "no prior authorization obtained."

ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings for approval along with the reasons.

d) Case is routed back to the UM Coordinator to complete the member and provider notifications.

e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH/ Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance QI Policy Potential Quality of Care Issues.

J. Referrals to Care Management

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service's needs, then the UM staff will complete the Care Management / CCS/ BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management /BH Policies.

K. Reporting and Tracking

1. All pre-service requests are entered into The Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
2. HealthCare Analytics has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.
3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services

1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
   a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.

b) UM Staff will process referral request as defined in Sections 3.1
c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH/ Pharmacy departments provides oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations** – pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

~~C.~~ **Behavioral Healthcare Practitioner (BHP)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical arear of practice.

~~D.~~C. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

~~E.~~D. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

~~F.~~E. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

~~G.~~F. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

~~H.~~G. **Doctoral Behavioral Health Reviewer** is a licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

~~I.~~H. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

~~J.~~I. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

~~K.~~J. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

~~L.~~K. **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

~~M.~~L. **Medical Necessity Determination** means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

~~N.~~M. **Member** means any eligible beneficiary who has enrolled in the The Alliance and who has been assigned to or selected a Plan.

~~O.~~N. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

~~P.~~O. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with The Alliance.

~~Q.~~P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

~~R.~~Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

~~S.~~R. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

~~T.~~S. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

~~U.~~T. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

~~V.~~U. **UM /BH Reviewer** is a Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. They apply QIHEC approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance Website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care

7. CM-009 ECM Program Infrastructure
8. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
9. RX-002 PA Review Process
10. UM - 054 Policy Notice of Action
11. UM -059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, , 7/17/2024, 10/25/2024

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REFERENCES

- SB 600, Section 1374.551. (a)
- "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- DHCS Provider Manual, Family Planning, June 2022, page 1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
- Title 22, Section 51159
- 28 CCR, §1300.51 (d)(I-6)
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- NCQA Standards, Utilization Management
- WIC Section 14197
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    ~~b.~~ Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability. The Alliance also ensure interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional detail about the Inter-Rater Reliability Process.

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirming Surgery and Services
Department Name	Health Care Services-Utilization Management
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2013
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the "Alliance") covers gender affirming medically necessary care for transgender and gender diverse members, consistent with the World Professional Association of Transgender Health (WPATH) Standard of Care for Transgender and Gender Nonconforming People for Group Care and Medi-Cal. Gender affirming medically necessary care for Medi-Cal members is consistent with DHCS **APL 20-018**.

1. The Alliance provides medically necessary covered services to all Medi-Cal beneficiaries and Group Care enrollees, including transgender diverse (TGD) beneficiaries Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals.
2. Medically necessary covered services are those services:
   a. Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
   b. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
   c. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
   d. "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of

preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

i. In accordance with the current generally accepted standards of mental health and substance use disorder care.

ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.

iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provide **(Health and Safety Code section 1374.72 (3) (A)).**

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:
   a. Mental health services, including psychotherapy;
   b. Gender affirming (GA) feminizing/masculinizing hormone therapy and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;
   c. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.
4. The Alliance must provide medically necessary reconstructive surgery to all Medi-Cal beneficiaries, including TGD beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible" **(Health and Safety Code § 1367.63 (c) (1) (A) (B)).**
5. In analyzing GA medical and surgical service requests, the Alliance must analyze GA requests under both the applicable medical necessity standard for services to treat gender dysphoria/incongruence and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.
6. If the Alliance determines that the service is medically necessary to treat the member's gender dysphoria/incongruence, the Alliance must approve the requested service. If the Alliance determines the service is not medically necessary to treat gender dysphoria/incongruence (or if there is insufficient information to establish medical necessity), the Alliance must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.
7. The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider ("PCP"), licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.
8. The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence, mental health or substance use disorders.
9. The Alliance is required to treat beneficiaries consistent with their gender identity **(Title 42 United States Code §18116; see also 45 CFR § 156.125).**
10. Federal regulations prohibit the Alliance from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a TGD beneficiary based on the fact that a beneficiary's gender assigned at birth, gender

identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available **(45 CFR §§92.206, 92.207 (b) (3)).**

11. DHCS indicates that Federal regulations further prohibits the Alliance from categorically excluding or limiting coverage for health care services related to gender transition **(DHCS APL 20-018).**
12. The Insurance Gender Nondiscrimination Act ("IGNA") prohibits the Alliance from discriminating against individuals based on gender, including gender identity or gender expression **(Health and Safety Code section § 1365.5).** The IGNA requires that the Alliance provide transgender beneficiaries with the same level of health care benefits available to non-transgender beneficiaries.
13. The Alliance may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determination, and/or apply appropriate utilization management criteria that are non-discriminatory. The Alliance may not categorically exclude health care services related to gender transition on the basis that it excludes those services for all members.
14. The Alliance must not categorically limit a service or the frequency of services available to a TGD member. For example, classifying certain services, such as facial feminization surgery as always "cosmetic" or "not medically necessary for any Medi-Cal member" is an impermissible "categorical exclusion" of the service. The Alliance must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."
15. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).
16. Medi-Cal is not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance" **(Health and Safety Code § 1367.63(d))** or self-esteem. However, if the service request is reconstructive in nature to improve function, and/ or for the alleviation or treatment of gender dysphoria/incongruence then it would be medically necessary.

PROCEDURE

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services;
- Psychotherapy;
- GA feminizing/ masculinizing hormone and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;
- Surgical and GA procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, which is not strictly cosmetic in nature. Sex reassignment surgery (also known as GA surgery), is a treatment option for TGD beneficiaries.

People with gender dysphoria/ incongruence often report a feeling of being born into the wrong sex. Sex reassignment is not a single surgical procedure, but part of a complex process

involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Before undertaking sex reassignment surgery, important medical and mental health assessments should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

Clinical guidance for the medical treatment of gender dysphoria is provided by the World Professional Association for Transgender Health (WPATH), under the current Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. The current WPATH Standards of Care falls under the AAH UM Policy UM-001's Hierarchy for Regulatory and Contractual Requirements for national specialty guidelines. Clinical guidance for the treatment of Substance Abuse Disorder is provided by American Society of Addiction Medicine, ASAM Criteria, 4th edition (2023). Clinical guidance for mental health disorders (age 18 or older) is provided by the American Association of Community Psychiatrist, Level of Care Utilization Systems (LOCUS), Version 20. Clinical guidance for the treatment of mental health disorders (age 6-17 years) is provided by the American Association of Community Psychiatrist, Child, and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or the American Academy of Child and Adolescent Psychiatry, the Child and Adolescent Level of Care/Service Intensity Instrument (CALOCUS-CASII). Edition 1.2 (2020). Clinical guidance for the treatment of mental health disorders (ages 0-5 years) is provided by the American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII).

The medical appropriateness of surgical services requested by a TGD beneficiary must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider or specialist; often it is a multidisciplinary team involved their care**.** The medical necessity and determination of a surgical procedure GA related or as reconstructive will be made by the Managed Care Plan.

I. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

Clients presenting with gender dysphoria/incongruence may have underlying mental health or medical conditions. This could include unique anatomical, social, psychosocial, and medical comorbidity considerations. Multidisciplinary teams including a mental health professional, GA specialist and/ or surgeon, other specialists, and PCP are often involved. Adolescents uniquely will need a biopsychosocial assessment before proceeding with GA medical or surgical interventions.

Although not an explicit criterion, a staged process that is defined by a surgeon in coordination with the member, is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions. New assessments and letters for each GA procedure are not required; multi-staged procedures do not require new mental health reapprovals. The health plan

reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

The intent of this suggested sequence is to give adolescents and adults sufficient opportunity to experience and socially adjust to the new gender role and achieve the desire optimal hormonal result. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression. It is recommended that health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment and hormonal treatment until the transition is made to adult care.

II. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures. (1 Letter/ Documentation)

One written documentation or letter is required from a qualified health professional who has competency in the assessment of TGD people, to recommend for medical or surgical treatment. This can be a single letter that summarizes the single opinion for medically necessary GA treatment.

Adolescents will additionally need a comprehensive biopsychosocial assessment: including input from relevant mental health and medical professionals. Involvement of parents(s)/ guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible[1]. A single letter from the adolescent's multidisciplinary team is needed and this letter can summarize the assessment and opinion from the team or single provider involving both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). It is recommended but not required for the health care professional to liaise with multidisciplinary trans health professionals who are from different disciplines within the field of trans health.

Although not explicit criteria, the recommended content of the letter for GA hormone therapy or surgical intervention from a health care professional who has competency in the assessment of TGD people is as follows:

- The client's general identifying characteristics
- An explanation that the criteria for GA hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made

[1] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

- The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- A statement that informed consent has been obtained from the member or parent/ guardian.
- A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy

An assessment and psychosocial interventions for adolescents are often provided within a multidisciplinary gender identity specialty service. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the member's chart as a comprehensive assessment. Although not explicit criteria, if such a multidisciplinary service is not available, then the health plan recommends that a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist[2] for the purpose of assessment, education, and involvement in any GA decisions.

If the GA surgeries are staged a single letter that outlines multiple staged interventions is also acceptable. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

III. Eligibility Criteria for Gender Affirming Hormone Therapy or Puberty Blocker Hormones for Adolescents (<18 Years Old)

Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. All of the criteria below must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained.
2. Meets the diagnostic criteria for gender dysphoria/ gender incongruence;
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives[3].
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. The adolescent has been informed of the reproductive effects, including potential loss of fertility and options for fertility preservation, and the context of the adolescent's stage of puberty development;

[2] If puberty blockers or gender-affirming hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone prescribing provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

[3] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

6. The adolescent has reached Tanner stage 2

IV. Eligibility Criteria Gender Affirming Hormone Therapy for Adults (≥ 18 Years Old)

All of the following criteria must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;
3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
5. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
6. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. Gender Affirming Surgery

A. Eligibility Criteria for Gender Affirming Surgery in Adolescents (< 18 Years Old)

For adolescents undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 8):

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
3. Demonstrates the emotional and cognitive maturity required to provider informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
6. At least 12 months of GA hormone therapy or longer, if required, to achieve the desired surgical result for GA procedures, including breast growth and skin expansion prior to breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty (with or without scrotoplasty), and facial surgery as part of GA treatment, unless hormone therapy is either not desired or is medically contraindicated.

B. Gender Affirming Surgery in Adults (≥ 18 Years Old)

For adults undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 7):

1. Gender dysphoria/ gender incongruence is marked and persistent;
2. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;
3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Understands the effect of GA surgical intervention on reproduction and they have explored reproductive options;
5. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;
6. Mental health and physical conditions that could negatively impact the outcome of GA surgical intervention have been assessed, and risks and benefits have been discussed;

While not an explicit criterion, it is suggested that the member is stable on their **GA hormonal therapy** (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

If requesting a GA gonadectomy surgery (i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) although not an explicit criterion, it is recommended that:

- The member has tolerated a minimum of 6 months of hormonal therapy (or longer period if required to achieve the desired surgical result), unless hormones are not clinically indicated, not desired, or medically contraindicated[4].

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence.

D. FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively. Examples include, but are not limited to, reconstructive procedures which correct or improve a significant functional impairment of speech, such as voice feminization/ modification surgery, nutrition, control of secretions, protection of the airway, or corneal protection. The health plan will provide medically necessary treatment of a mental health and

[4] The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's request for facial reconstruction surgery. **All basic GA surgery criteria must be met (1-6).**

Facial feminization surgery is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or to treat gender dysphoria/ gender incongruence. Facial feminization surgery is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance (cosmetic in nature).

Note: The initial restoration may be completed in stages. New mental health assessments and letters are not required for each staged GA procedure; they do not require reapproval.

Voice feminization surgery to obtain a higher voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective. All basic GA surgery criteria must be met (1-6).

Although not explicit criterion, it is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication.

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence, or physical functional impairment/ physical reconstruction.

Voice and communication therapy may be medically necessary to treat gender dysphoria/incongruence, or to help individuals develop verbal (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication skills (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity through individual and/or group sessions, and to prevent the possibility of vocal misuse and long-term vocal damage. Therapy is conducted with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/ speech-language pathologists. These pre and post interventions may be needed after voice surgery, or testosterone therapy.

For the following GA reconstructive procedures:

All basic GA surgery criteria must be met (1-6). Additionally, they are medically necessary if they treat gender dysphoria/incongruence, or to treat physical functional impairment/ physical reconstruction. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested facial reconstruction surgery.

1. **Blepharoplasty, Blepharoptosis Repair, and Brow Lift**
   Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

2. To treat gender dysphoria/gender incongruence;

a. Difficulty tolerating a prosthesis in an ophthalmic socket; or
b. Repair of a functional defect caused by trauma, tumor, or surgery; or
c. Periorbital sequelae of thyroid disease; or
d. Nerve palsy

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

3. Blepharoplasty

Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, and c-d):

a. To treat gender dysphoria/gender incongruence; or
b. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; and
c. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue; and
d. Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:
   1) less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and
   2. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

4. Eye Lid Surgery (Blepharoptosis Repair)

Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, c through e):

a. To treat gender dysphoria/gender incongruence; or
b. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and
c. Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); and
d. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; and

e. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

5. Brow Lift

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. Photographs show the eyebrow below the supraorbital rim.

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.

- Blepharoplasty, blepharoptosis repair, or brow lift is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance.

- Lower lid blepharoplasty is considered not medically necessary.

- Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature, or there is a medical need to treat gender dysphoria/gender incongruence**.**

6. Otoplasty

Otoplasty is considered medically necessary when performed to surgically correct a physical structure or absence of a physical structure that is causing hearing loss, or intended to facilitate the use of a hearing aid or device when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The procedure is reasonably expected to improve the physical functional impairment; and

c. An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Otoplasty is considered reconstructive when intended to restore a significantly abnormal external ear or auditory canal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered reconstructive when intended to restore the absence of the external ear due to accidental injury, disease, trauma, or the treatment of a disease

or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered not medically necessary when performed strictly to alter or reshape normal structures of the body to improve appearance. Examples include, but are not limited to, repair of ear lobes with clefts or other consequences of ear piercing, or protruding ears.

Otoplasty is considered not medically necessary when the gender dysphoria/gender incongruence, or medically necessary reconstructive criteria in this section are not met.

7. Nasal Procedures - Rhinoplasty or rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
Rhinoplasty is considered medically necessary when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or
b. The medical record documentation includes evidence of the failure of conservative medical therapy for severe airway obstruction from deformities due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone; and
c. The procedure can be reasonably expected to improve the physical functional impairment;

- Rhinoseptoplasty is considered medically necessary when gender dysphoria/gender incongruence, or the criteria above for rhinoplasty are met and medically necessary criteria in MCG guideline ACG: A-0182 Septoplasty are also met.

- Rhinoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal fracture.

- Rhinoseptoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal and septal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal and septal fracture.

- Rhinoplasty or rhinoseptoplasty to modify the shape or size of the nose is considered not medically necessary when the gender dysphoria/gender incongruence medical necessity, or reconstructive criteria in this section are not met.

8. Face lift (Rhytidectomy)

Rhytidectomy is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

Rhytidectomy is considered not medically necessary when the gender dysphoria/gender incongruence, or reconstructive criteria in this section are not met, including but not limited to, removal of wrinkles, excess skin, or to tighten facial muscles.

9. Hair Removal

Hair removal consultation is covered for the genital area when authorization is in place for gender GA surgery, or it is necessary intervention in preparation for surgery. Consultation is needed for the removal of body hair from the face, neck, chest, back, abdomen, genitalia, arms, and legs if there is persistent gender dysphoria/ gender incongruence for feminization gender affirming care, or there is significant disruption of professional and/ or social life because of hirsutism with some medical evaluation outlining the psychological distress related to unwanted hair and justification of medical necessity[5]. Other medical reasons may include if the hair loss response has not been achieved after hormone therapy was trialed, or if hormone therapy is contraindicated. Hair reduction procedures include:

(a) Laser Epilation/Hair Removal require:

(i) to be provided by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for the specific body areas

(b) Electrolysis Hair Removal require:

(i) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for the specific body areas
(iv) Electrolysis will be provided by a licensed electrologist.

E. Additional Procedures for Body Feminization or Body Masculinization

The following procedures are medically necessary when they are requested for the treatment of gender dysphoria/ gender incongruence, or reconstructive surgery (to correct or repair abnormal structures of the body to create a normal appearance for the target gender to the extent possible). All basic GA surgery criteria must also be met (1-6). The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested surgical or reconstructive procedure.

[5] https://transcare.ucsf.edu/guidelines/hair-removal

- Abdominoplasty
- Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
- Cheek surgery
- Chin Shaping
- Facial bone reconstruction
- Gluteal augmentation
- Hair removal/ hairplasty, when the criteria above have not been met.
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Suction-assisted Lipoplasty/ trunk contouring
- Otoplasty
- Tattoo (i.e., nipple/ areola)
- Penile prosthesis in the setting of proposed or completed phalloplasty
- Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- Voice Modification Surgery

F. Revisions of Gender-Affirming Surgery (1 Letter Assessment)
The Alliance authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria/ gender incongruence and/or reconstructive surgery. Clinical documentation must support medical necessity to treat gender dysphoria/ gender incongruence or reconstructive surgery. Surgical revision requests require all of the following:

a. Medical and/or functional complications of prior GA procedure;
b. Measurements and/or photographs of deformity/asymmetry (if applicable);
c. Members who regret their GA surgical intervention are to be managed by an expert multidisciplinary team.
d. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

VI. Standard Fertility Preservation Services
For coverage options please refer to the UM-057 policy under the Standard Fertility Preservation Services section.

DEFINITIONS / ACRONYMS

DISORDERS OF SEX DEVELOPMENT (DSD): Refers to a group of medical conditions (i.e., Klinefelter Syndrome, Turner Syndrome, Androgen Insensitivity Syndrome, Congenital Adrenogenital Disorders, Congenital Adrenal Hyperplasia) in which anatomical, chromosomal, or gonadal sex varies in some way from what would be

typically considered male or female. The *DSM–5* criteria for gender dysphoria were revised to allow the diagnosis to be given to individuals with DSD.

EMANCIPATED MINOR: A minor (person who is not an adult) who is self-supporting and independent of parental control, usually as a result of court order (Cal. Fam. Code § 7122). Some examples are persons under the age of 18 who are married, or a minor who is on active duty with the armed forces (Cal. Fam. Code § 7002).

EUNUCH: People who are assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. This also includes those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as eunuch. This doesn't include men who have been treated for advanced prostate cancer and reject the designation of eunuch.

FEMALE TO MALE (FtM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery.

GENDER-AFFIRMING HEALTH CARE: means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:

- Interventions to suppress the development of endogenous secondary sex characteristics.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.

GENDER DYSPHORIA:
DSM-5 defines gender dysphoria as the distress that may accompany incongruence between one's experienced or expressed gender and one's assigned gender at birth. Gender dysphoria is treated as a developmental abnormality for purposes of the reconstructive statute and normal appearance is to be determined by referencing the gender with which the member identifies **(Health and Safety Code 1367.63(c)(1)(B)).** Gender non-conformity is not in itself a mental disorder.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN[6]

[6] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion 1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play of fantasy play.
- A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

GENDER DYSPHORIA/ GENDER INCONGREUENCE IN ADOLESCENTS AND ADULTS[7]

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
    2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
    4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if there is a DSD that is also relevant. Coding note: Code the disorder of sex development as well as gender dysphoria/ gender incongruence.

[7] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

GENDER NON-BINARY
Non-binary or gender queer is a spectrum of gender identities that are not exclusively masculine or feminine—identities that are outside the gender binary. Non-binary identities can fall under the transgender umbrella, since many non-binary people identify with a gender that is different from their assigned sex. The term nonbinary includes people whose genders comprise more than one gender identity simultaneously or at different times (e.g., bigender), who do not have a gender identity or have a neutral gender identity (e.g., agender or neutrois), have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl), and/or who have a gender that changes over time (e.g., genderfluid)

IATROGENIC INFERTILTY
Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

MALE TO FEMALE (MtF)
A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery.

MEDICAL NECESSITY
- Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
- For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
- "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    - In accordance with the current generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provide **(Health and Safety Code section 1374.72 (3) (A)).**

POST TRANSITION
The individual has transitioned to full-time living in the desired identity-congruent gender role (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-

sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

QUALIFIED MENTAL HEALTH PROFESSIONAL
The mental health professional must have appropriate training:

- Have a Master's degree or, equivalent or higher, in a clinical mental science field (such as social work, psychology or marriage and family therapist) and licensed by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution
- Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

QUALIFIED MEDICAL PROFESSIONAL

- The medical professional must have appropriate training and licensed to by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

RECONSTRUCTIVE SURGERY
In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/incongruence. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible. **(Health and Safety Code 1367.63).**

TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE: A broad and comprehensive as possible phrase in describing members of the many varied communities

that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. May include non-binary, eunuchs, and other non-confirming gender identities.

STANDARD FERTILITY PRESERVATION SERVICES
Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CMP-008 Members Rights to Release PHI

CMP-015 Minor Consent to Medical Care

G&A-008 Adverse Benefit Determination Appeals Process

RX-002 PA Review Process

RX-003 Exception Review Process

RX-004 Formulary Management

UM-001 Utilization Management Program

UM-012 Care Coordination-Behavioral Health

UM-062 Behavioral Health Treatment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2013, 11/15/2018, 10/29/2020, 12/14/2020, 1/21/21, 05/20/2021, 08/24/2021, 4/27/2022, 6/28/22, 9/27/2022, 02/21/2023, 6/20/2023, 10/19/2023, 3/19/2024

REFERENCES

DHCS: All Plan Letter [APL] 20-018: Ensuring Access to Transgender Services

DHCS Provider Manual, Family Planning, August 2020.

DMHC All Plan Letter [APL] 20-002: Implementation of SB 855, MH.SUD Coverage

State Laws:

Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020). Section 1374.551. (a)

Insurance Gender Nondiscrimination Act - Health & Safety Code § 1365.5
Civil Rights Protections - Govt. Code § 11135
Department of Fair Employment and Housing Definitions -Govt. Code § 12926 (r)(2)
DMHC Director's Letter 12-K Gender Nondiscrimination Requirements

Federal Laws:

Nondiscrimination in Health Programs or Activities Receiving FFA or Administered by DHHS Under Title I of the ACA - 45 CFR §§ 92.206, 92.207
Section 1557 of the ACA - 42 USC § 18116

National Organizations:

WPATH [World Professional Association for Transgender Health], the current Standards of Care for the Health of Transgender and Gender Diverse People.

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012; 51(9):957-974. Summary on National Guideline Clearinghouse [website].

American Psychiatric Association (APA). Gender Identity Disorder. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association; 2000.

UCSF Gender Affirming Hair Removal guidance : https://transcare.ucsf.edu/guidelines/hair-removal

Publications:

American Psychological Association. (2015). Guidelines for professional practice with transgender and gender non-conforming people. American Psychologist, 70(9), 832–864.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology & Metabolism, 94(9), 3132– 3154. doi:10.1210/jc.2009–0345

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. Medical Journal of Australia, 209(3), 132–136.

MONITORING

Annual audit based on CPT codes submitted.